Australian Government
Department of Health and Aged Care

Support at Home program claims and payments business rules guidance

Stage 1 – November 2025

Version 1.5

01/08/2025

Contents

Version history

Date	Summary of changes
February 2025	Claims and payments business rules guide (v1.0) first issued.
August 2025	Claims and payments business rules guide update (v1.5) Refinements to the following section to reflect up-to-date information: Section 3.3 – Payment in Arrears Refinements to entry and exit scenarios Addition of evidence upload rules Section 3.4 – Care Management Refinements to Care Management account creation and calculation Section 3.5 – Participant Unspent Budget Refinements to Unspent Fund accrual determination. Section 3.6 – Participant Contributions Refinements to AT Loaned Item contribution Refinements to Participant Contribution exemptions for Victoria Cross recipients and/or former Prisoners of War Addition of DVA means testing rules Section 4.3 – Restorative Care payments Minor Clarifying refinements to business rules Section 4.5 – AT-HM scheme funding Refinements to AT High Tier process Addition of evidence upload rules The addition of Transition business rules that cover: Transition of Unspent Funds Transition of Participant contributions to Support at Home

	Setting up Care Management Accounts for Existing HCP Clients The addition of Appendix A, which includes the following FAQs content developed for software developer webinars: Service Delivery Branches Unspent Funds Support at Home Claim Evidence The addition of Appendix B, which includes pre-transition contribution rate examples.

1. Introduction

1.1 Document purpose

The purpose of this document is to give guidance for providers who will be operating under Support at Home from November 2025. This is a reference document for in-home aged care providers and gives context for understanding the business intent detailed in ICT Technical Specification for claims and payment processing.

This document is an extract from the Support at Home program business requirements and reflects legislation and policy guidance as of July 2025. As further consultation on the *Aged Care Act 2024* rules and policy guidance is refined, this document may be updated.

1.2 How to read this document

Information is grouped by specific focus areas, and includes:

- **Business processes:** High level future state business processes are provided as context to the business rules, with a focus on what needs to change
- **Assumptions:** Statements outlining key assumptions made with regard to current policy guidance
- **High level business requirements:** High level business requirement statements
- **Description of business requirements:** The user story and relevant business rules to enable the outcome for the user as set out in Table 1: Business requirements content guide.

Table 1: Business requirements content guide

Heading	Description
Requirement title (ID and short name)	Requirement title with unique identifier and easy to use short name for reference purposes.
Description	Statement describing business requirement in the format: ***As a***…: Stakeholder group(s) impacted by the requirement at a business process level… ***User Story:*** I want to… perform a specific action/task/activity… ***so that…:*** an outcome or benefit can be achieved.
Business rules	Business rules provide additional detail to ensure policy intent is being met.

1.3 Glossary

Table 2: Glossary

Term	Definition
AT-HM scheme	Assistive Technology and Home Modifications scheme
CALD	Culturally and linguistically diverse
Care partner	An appropriately trained person who provides care management services for Support at Home participants in an ongoing classification or accessing End-of-Life Pathway.
Classification	Refers to the classification level of a Support at Home participant, including: • ongoing classification (Class 1-8) • short-term classification (Restorative Care classification, End-of-Life classification, and Assistive Technology and Home Modifications).
CHSP	Commonwealth Home Support Program

Term	Definition
CSHC	Commonwealth Seniors Health Card
Participant	An individual who is receiving services under Support at Home.
HCP	Home Care Package
Health professional	A person employed in a profession delivering health care, who holds a recognised qualification or accreditation in their field of practice and/or is registered with the Australian Health Practitioner Regulation Authority.
ISP	Income support payment. Refer to Table 12: List of income support payments (ISP).
MAC ID	My Aged Care identification
Needs assessment	Holistic, multi-disciplinary evaluations to determine a person's eligibility to access Commonwealth funded aged care. Replaces existing Simple and Complex assessments.
Provider	A provider who is registered to deliver Support at Home. This does not refer to subcontractors, third party organisations and broker organisations.
Representative	A person allocated by the participant, or a representative organisation staff member, who is authorised to undertake specific actions (financial or care giving) on a participant's behalf.
Service agreement	An agreement entered into by a participant and a provider outlining rights and responsibilities and what services will be provided to the participant under the Support at Home classification.
SPR	Support Plan Review

2. Business context

2.1 Background

The Royal Commission into Aged Care Quality and Safety set out the foundations of a new aged care system including a new act, purpose, and principles. The driving principle was to ‘place people at the centre’ of aged care. The changes to aged care in Australia aim to achieve 6 main outcomes:

- dignity and respect in aged care
- self-determination through choice and control
- quality of life in aged care
- caring relationships that leave older people feeling heard, seen, and respected
- preference for older people to receive care in their homes
- aged care recipients remaining engaged and valued in their community.

In response to the Royal Commission into Aged Care Quality and Safety, the government has committed to establishing a new Support at Home program in consultation with older people and community stakeholders. The Support at Home program will replace the Home Care Packages (HCP) Program and Short-Term Restorative Care (STRC) Programme from 1 November 2025.

The Commonwealth Home Support Program (CHSP) will transition to the Support at Home Program no earlier than 1 July 2027.

The generational plan for aged care will create an aged care sector that:

- is simpler to navigate, with face-to-face services to find care
- empowers older people to make informed choices
- is strongly regulated
- is more transparent
- makes sure providers are accountable
- values and grows the aged care workforce.

2.2 Key objectives

The Support at Home program will make entering aged care easier to navigate, with less duplication and a less fragmented experience for older people.

Key objectives include:

- a modern classification and funding system to ensure the support older people receive aligns with their assessed care needs
- a separate claiming mechanism for dedicated care management funding including payments in arrears to improve transparency around care management delivered to individuals
- better support for informal carers

- more support for early interventions and short-term pathways to help older people to remain independent at home for longer.

Almost one million older people are currently receiving support from the Australian Government to access aged care services in their own homes. Care at home is overwhelmingly the preference for older people.

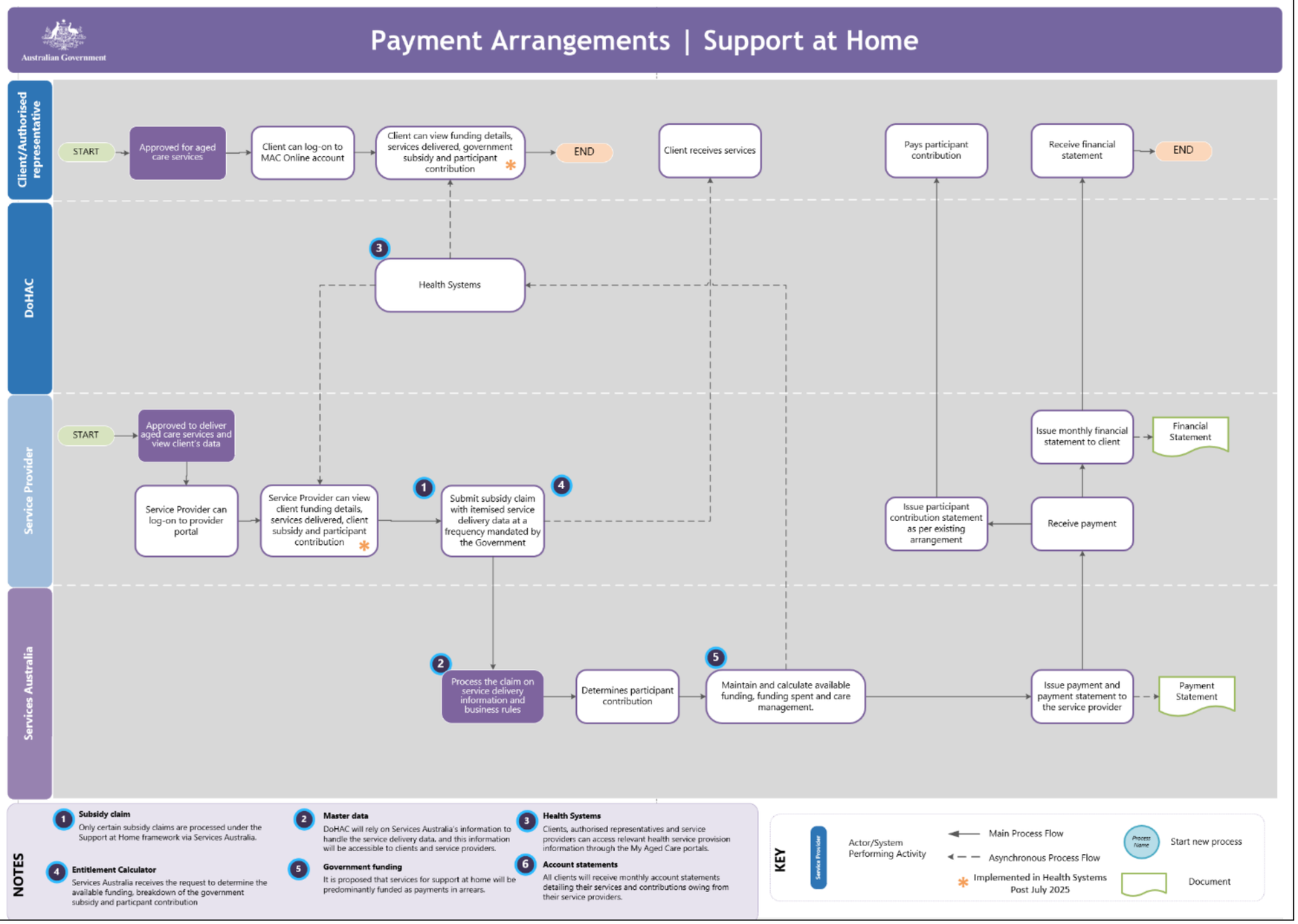
3. Payments – ongoing services

3.1 Future state business process

Here are the key changes from 1 November 2025 for existing HCP recipients transitioning to Support at Home:

- **Quarterly budget**: The annual HCP will be divided into four equal quarterly budgets. Quarterly funds that have not been used can accrue to the next quarter up to $1000 or 10% of the quarterly budget, whichever is higher.
- **Defined service list**: All services under Support at Home will be specified with clear inclusions and exclusions, similar to the current HCP.
- **No separate administration charges**: Package management costs will be included in prices, not charged separately.
- **Care management funding**: 10% of all quarterly budgets will be allocated for care management support.
- **Assistive Technology and Home Modifications (AT-HM) scheme**: Separate funding will be approved for assistive technology and/or home modifications during assessment.

Figure 1: Payments process flow diagram



3.2 Assumptions

Table 3 outlines the key assumptions related to payments for ongoing services. These assumptions address factors such as provider service delivery, subsidy payments, entry/exit rules, individual participant contribution, *Aged Care Act 2024* provider registration and deeming regulatory requirements.

Table 3: Payments – ongoing services assumptions

Assumptions	
1	A provider delivering subsidised services under the Support at Home program will be paid by Services Australia from subsidy funds allocated for a participant.
2	Providers will be paid for services under the Support at Home program by payment in arrears subsidy payments.
3	Subsidy payments for the Support at Home program will be managed by Services Australia.
4	A participant with ongoing services will continue to receive financial statements including a participant's contributions, paid at a minimum frequency of monthly, from their providers.
5	Providers will continue to receive Payment Statements from Services Australia. It will reflect the services provided and already claimed by the provider for the period.
6	Providers are not permitted to claim for services outside of a participant's approved services in their Notice of Decision. Providers can only claim for services that have been agreed with the participant and must use the agreed prices in the claim.
7	Providers should maintain records and evidence to support the claimed amounts and ensure compliance with program guidelines.
8	There is a provision in the *Aged Care Act 2024* that enables the delegate to determine a longer variation period under specific circumstances (to be defined in policy e.g. human error).
9	Providers that deliver Support at Home services, including care management services, will need to be registered against the relevant

Assumptions	
	service categories under the *Aged Care Act 2024* provider registration and deeming regulatory requirements.
10	HCP grandfathered unspent funds can be used for either assistive technology and home modifications (and are to be used before any AT-HM scheme funding is used); or to top up the Support at Home budget once it has been exhausted.
11	Participants will be required to contribute towards the cost of their care for services under the Support at Home program based on their aged pension means test.
12	Individual contribution payments will be paid directly by the participant to the provider.
13	When a participant's pension or CSHC status has changed, Services Australia will notify the provider. Providers will reconcile individual amounts within 30-days of notification.
14	A participant who self-manages can choose their own workers if their provider permits this, based on their assessed need and care plan.
15	For the Restorative Care Pathway, End-of-Life Pathway and AT-HM scheme, providers are required to provide a final statement to the participant upon conclusion of the episode.

3.3 Payment in arrears

3.3.1 HL-PIA-1 Manage subsidy payment

Description

Services Australia to manage and process subsidy payments.

Business value

Subsidy-based services delivered under the Support at Home program will be paid on a payment in arrears basis.

Services Australia will manage and process payment claims, including the calculating of individual contributions and issuing payment statements.

Providers can make subsidy payment claims with Services Australia on a monthly or more frequent basis (maximum daily).

3.3.1.1 DBR-PIA-1.1 Services Australia calculates quarterly participant budget

Description:

Services Australia to calculate participant budget so that the payment can be processed for services provided.

Business rules:

BR1. Services Australia will be notified of the Support at Home classification and AT-HM funding tier reference data. Management of AT-HM payments are described in ***4.5.1.1 DBR-ATP-1.1 Services Australia validates and manages***

BR2. Services Australia will be notified of the classification for each participant in the care approval information, which will be electronically communicated to Services Australia by the Department of Health, Disability and Ageing.

BR3. The annual rate for each participant will consist of the amount of funds attributed to the classification they have been assigned through their needs assessment.

BR4. Services Australia will calculate the daily rate of funding based on the classification for each participant. i.e., this means each quarterly budget may have a different amount.

BR5. For the first financial quarter of Support at Home, quarterly budget is calculated based on participant's daily rate, multiplied by the number of days within the quarter.

Table 4: Payments – quarterly budget calculation

Participant's daily rate = 90% of annual Support at Home classification amount divided by the number of days in the financial year

Participant's quarterly budget = Participant's daily rate multiplied by the number of days in the quarter + unspent funds + quarterly supplement budget

(See ***Table 13: Payments – quarterly supplement budget calculation*** for how quarterly supplement budget is calculated)

The participant's daily rate is expected to be equal to the base individual amount in the Aged Care Rules.

*Unspent funds: Unspent funds from the previ**ous** quarter can be rolled over, once claims from the previous quarter are finalised, based on business rules.

BR6. All Support at Home ongoing funds will be based on a quarterly cycle within the typical financial year, with quarters commencing 1 July, 1 October, 1 January and 1 April each year.

BR7. Providers will be able to claim for the current quarter before they've finalised all claims for the previous quarter.

BR8. A participant's budget will be calculated from the participant entry date Services Australia receives in the participant entry notification from the provider.

BR9. The participant entry date received in the participant entry notification cannot be a future date.

BR10. For a participant who has the participant entry date partway through a quarter, the first day of their quarter is the participant entry date. The participant's budget will be calculated on a pro-rata basis from the participant entry date to the end of the quarter.

BR11. If a participant's ongoing classification amount changes because of a reassessment or CPI change or transitioning from minimum to full service offer, the difference between the participant's updated budget and previous budget will be credited to the participant's quarterly budget.

- The period to account for the calculation of the difference will be pro rata from the effective date of the updated budget to the end of the quarter. For example:
  - Previous quarterly budget for full quarter (90 days) = $1000
  - Updated budget effective from day 46 of quarter

- Calculate updated daily rate (derived from the updated annual budget)
- Daily rate difference = Updated daily rate minus previous daily rate
- Additional pro-rata amount from day 46 to 90 = Daily rate difference multiply by 45 days = $600
- $600 (minus care management %) will be credited to the participant's quarterly budget.

BR12. If a participant is in an ongoing Support at Home classification and enters the End-of-Life Pathway, Services Australia will restrict claiming for services delivered for the ongoing Support at Home classification after the day the participant starts in the End-of-Life Pathway classification.

- Services Australia to continue to credit the participant's ongoing Support at Home account including accruals
- Provider will have 60 days from the End-of-Life Pathway start date to submit claims for ongoing Support at Home services delivered prior to End-of-Life Pathway start date.

BR13. Payment for services to participants can be claimed from various budgets, however will be prioritised in the following order:

a. Participant budget.

b. HCP unspent fund*

* for the AT-HM fund, the order is HCP unspent fund then AT-HM fund.

BR14. When the provider's claim for a service is finalised, the subsidy amount and the participant contribution amount will be debited from the participant's budget.

BR15. Where HCP unspent fund is used for the claim, participant contribution will not be debited for the unspent funds portion of the claim but will still be invoiced to the participant by the provider.

Note: For guidance on participant unspent budget please refer to the Support at Home program handbook and program manual (release pending).

Compensation reduction

BR16. Compensation reduction is applicable to all Support at Home ongoing and short-term funding classifications.

BR17. For a participant who is eligible for full compensation, i.e. an insurance company agrees to pay the full cost of a participant's care, a 100% compensation reduction fee is to be applied against the price charged by the provider.

- Services Australia issues payment statement to the provider, the provider then reconciles with the participant, the participant then informs the insurer. The insurer will pay the provider the full price charged (inclusive of subsidy and participant contribution amount), as per current process.

BR18. For a participant who is eligible for partial compensation, i.e. an insurance company agrees to pay only part of the cost of a participant's care:

- the agreed compensation reduction fee percentage is to be applied against the price charged by the provider
- participant contribution amount, if applicable, will be calculated on the remaining price charged after the compensation reduction fee has been debited (price charged minus compensation reduction % of price charged)
- the subsidy payable to the provider is the amount after compensation reduction fee and participant contribution amount have been debited from the price charged
- Services Australia issues payment statement to the provider, then the participant informs the insurer to pay the provider the compensation reduction fee as per current process.

For example:

Provider charges $100 for a service in the independence category

- compensation reduction percentage: 50%

- applicable price after compensation reduction: $50

- assuming participant is full pensioner with 5% participant contribution applicable for Independence category: 5% of $50 = $2.50

Subsidy payable to the provider = 50 - 2.5 = $47.50

Services Australia issues payment statement of $50 compensation reduction fee to the participant as per current process.

Participant's exit notice given by provider to Services Australia

BR19. The losing provider has 28 days from the exit date or gaining provider entry notification (whichever comes earlier) to notify Services Australia their participant is leaving.

- if the gaining provider entry notification comes earlier, then Services Australia to notify the losing provider of the participant's departure.

BR20. The provider would still follow regular exit claiming rules**.**

No subsequent entry received after participant's exit from Support at Home

BR21. After a participant's exit notice is given by a provider:

- Services Australia notifies Department of Health, Disability and Ageing (the department) 269 days from the exit date so that a 'Reminder to re-enter Support at Home' letter is sent by the department to the participant on the 270th day
- Services Australia will continue to credit the participant's account based on the participant's daily rate (i.e. with 10% care management deduction applied), including supplements and accruals for 4 quarters after the quarter in which the exit date falls, if no subsequent entry notice is provided.
- The account will be reduced to zero and no credit will be provided from the first day of the 5th subsequent quarter.

Example: If a participant's exit date is 31 January 2026 (i.e. quarter ends 31 March 2026), then the account will be reduced to zero on 1 April 2027 (i.e. after days to end of quarter = 1 February to 31 March + 4 quarters).

Entry into residential care after participant's exit from Support at Home

BR22. After a participant's exit notice is provided by a service provider:

a. If the participant enters residential care at any time before the participant's account is reduced to zero, then no credit will be provided after the participant's entry date into residential care.
b. The participant's account will be reduced to zero on the first day of the subsequent quarter.

Example: Support at Home exit date = 31 January 2026 (participant budget = $2000).

Residential care entry date = 20 March 2026 (less than 60 days after Support at Home exit).

On residential care entry date no further credits are applied.

Participant's account reduced to zero on first day of subsequent quarter (1 April 2026).

c. Even if the residential care entry notification is submitted late, and the residential care start date would have been in the previous quarter and the next quarter was credited, the effective date for zeroing the participant's ongoing Support at Home account should have been the first day of the quarter. Therefore, on the date the residential care entry notification is received, the account is reduced to zero.

Example: The quarter (1 April 2026 – 30 June 2026) got credited on 31 March 2026

Services Australia receives a later residential care entry notification after the new quarter is credited, on 15 April 2026 with residential care entry date = 15 February 2026 (previous quarter entry date).

Participant's Support at Home account is reduced to zero on 15 February 2026 (immediately upon receiving the residential care entry date

No exit notice given by provider to Services Australia

<u>No subsequent participant entry received</u>

BR23. If no exit notice is given by the provider:

a. Services Australia to notify Department of Health, Disability and Ageing 269 days from the last service delivered so that a 'Reminder to resume Support at Home services' letter is sent by the Department to the participant on the 270th day.

b. Services Australia will send a reminder to the provider on the last day of the 4th quarter after the quarter in which the last service was delivered, to notify that they have 60 days to finalise claims.

c. Services Australia will continue to credit the participant's account including supplements, accruals and care management for 4 quarters after the quarter in which the last service was delivered, and no subsequent entry notice was provided.

d. The account will be reduced to zero and no credit will be provided from the first day of the 5th subsequent quarter. Services Australia to disengage (auto-exit) the participant from the provider and provide new exit reason.

e. The department to receive auto-exit notification from Services Australia with the new exit reason and immediately withdraw participant's funding similar to the residential care entry rule.

Example: If a participant had their last service delivered on 31 January 2026, the account will be reduced to zero on 1 = April 2027 (i.e. after days to end of quarter = 1 Feb to 31 March) + 4 quarters.

Subsequent entry into residential care

BR24. If no exit notice is supplied by the provider and the participant enters residential care at any time before the participant's account is reduced to zero:

a. No credit will be paid after the participant's entry date into residential care.

b. The participant's account will be reduced to zero on the first day of the subsequent quarter.

Example:

Residential care entry date = 31 March 2026.

Support at Home exit date = 31 January 2026 (auto-exit).

On residential care entry date, no further credits are applied.

c. Participant's account reduced to zero on first day of the subsequent quarter (1 April 2026).

d. Services Australia to notify the provider that they have 60 days from residential care entry date to finalise their claims.

e. Even if the residential care entry notification is submitted late, and the residential care start date would have been in the previous quarter and the next quarter was credited, the effective date for zeroing the participant's ongoing Support at Home account should have been the first day of the quarter. Therefore, on the date the residential care entry notification is received, the account is reduced to zero.

BR25. If a participant would like to return to Support at Home, the provider is required to submit an entry into Support at Home and the participant's budget will be calculated on a pro rata basis from the date of entry.

BR26. The participant's account remains open for the lifetime of the participant.

3.3.1.2 DBR-PIA-1.2 Services Australia validates subsidy claim

Description:

Services Australia receives and validates provider's claim, so that payments can be processed.

Business rules:

BR1. Services Australia validates that a claim meets the following provider requirements:

- A provider is registered for specific categories to deliver the services under the Support at Home program
- A provider can only claim:
    - for a service approved for the participant
    - for a service type they are registered to deliver
    - for only the period the participant is under the provider's care. I.e. the date of service delivery is between the participant's most recent entry date and their exit date (if an exit date is on record after the most recent entry date)
    - a participant can only receive ongoing and short-term services simultaneously from a single provider at any given time (with the exception where a participant may also be receiving services through a CHSP provider)
    - **Note:** a provider is required to notify Services Australia of a participant's entry date within 28 days of the service agreement.

BR2. Services Australia validates the following requirements:

- a participant is a valid My Aged Care participant and has a current allocated Support at Home classification
- Participant is approved for the service(s) the claim is being made for under the relevant approved budget
- Participant has a sufficient quarterly budget and/or other relevant funding sources.

BR3. A successful claim meets the following cross-program requirements:

- where a participant has simultaneous program entries, e.g. Support at Home and residential respite at the same time, different services can be claimed for on the same date. However, the same service can only be claimed from both programs on the entry and exit dates (e.g. the nursing cannot be claimed by the Support at Home provider and residential respite provider for the same day except on entry or exit for the respective programs)
- where a participant exits Support at Home and enters residential care on the **same day,** services from both programs can be claimed on residential care entry date, regardless of whether they are the same services or not. Services delivered through Support at Home can only be claimed up to the residential care entry date
    - a participant may be approved to access both Support at Home and residential care, however a participant cannot be entered into Support at Home and residential care at the same time.
    - Services Australia validate entry and payments only for the programs it manages.

BR4. A submitted claim contains the following mandatory information:

- an identifier of the participant who received the service
    - Participant name
    - Participant MAC ID
    - Services Australia participant identifier
    - pooled funding participant indicator if applicable.
- an identifier of the provider who submitted the claim (and provided the service)
    - Provider identifier
    - Provider name

    - Provider location
    - service delivery date
    - claim date.
- the associated Support at Home service identifier of the service type provided to the participant
    - service type
    - service
    - service delivered by a third-party organisation indicator
    - service unit type
    - service unit price.
- the associated Support at Home funding details of the service provided to the participant.
    - number of units
        - if service list has unit type of ‘hour’ then it will support part-hour claims of 15, 30, 45 and 60 minutes
    - funding source.
- the funding source will be system allocated in most scenarios
    - the exception is when a participant is receiving both an ongoing Support at Home classification and Support at Home Restorative Care Pathway:
        - the provider will be required to manually select funding source ‘participant quarterly budget’ for claiming services delivered as part of the ongoing Support at Home classification. When the participant’s quarterly budget is exhausted, use HCP Commonwealth unspent fund, if available. Where the claim is for care management, use Care Management Account funding
        - the provider will be required to manually select funding source ‘Restorative Care Pathway budget’ to claim for services delivered as part of Support at Home Restorative Care Pathway. When Restorative Care Pathway budget is exhausted, use HCP Commonwealth unspent fund, if available. Claims for the ‘Restorative care management service’ will also use Restorative Care Pathway budget.

BR5. A successful claim meets the following funding source and fund availability requirements:

- the date of service delivered cannot be in the future
- before or after 60 days have elapsed since the end of the quarter, there will be an exceptions process for claiming for specific circumstances, with the delegate to determine length at their discretion. Policy guidelines will be provided in the Support at Home program manual

> **Day 0:** End-of-the-quarter
>
> **Day 1 - Day 60:** The provider has 60 days from the end of the quarter to claim/vary the payment.
>
> **Day 61 onwards:** The provider cannot claim from day 61 after the end of the quarter unless they have an exception from a delegate (the time limit the delegate prescribes is on a case-by-case basis).

- a provider is required to finalise all their claims prior to day 61 into the new quarter. However, the Services Australia delegate may also grant a different variation period after day 60 or after they have finalised all their claims for the quarter, due to exceptional circumstances
    - **Note:** a provider may submit a request for exception, even if the provider has submitted their claims before day 60.
- a provider cannot claim for services delivered from a previous quarter, against the current quarter's budget
- it is allowed for a claim to be made for the same service for the same participant for the same day
- only one provider can make a claim for a participant for any given day
- no unusual / inconsistent patterns in claims have been identified
- a provider has 60 days after the day that a participant leaves to submit their claims for that participant.

BR6. A provider has 60 days from the day after the participant's death to finalise all claims for the deceased participant, unless given approval for an exceptions process.

- the exceptions process requested by the provider should be within 60 days from the day after the participant's death

- if an exceptions process was not requested, the participant's account will be closed on day 61 after the participant's death
- if an exceptions process was requested, the participant's account will be closed at the end of the variation period approved by Services Australia
- once the participant's account is closed, an exceptions process will not be available.

BR7. Providers are required to claim the full cost of the services delivered in the claim. If there are not sufficient funds in the participant's budget, the provider absorbs the outstanding cost. Any outstanding amount cannot be added to a future claim, except in the case of system errors.

Note: There will be further information about the transitional HCP group and grandfathering.

BR8. The provider will have the option to upload evidence for the following Home Support services (for any Support at Home classifications: Support at Home Ongoing / Restorative Care / End-of-Life):

a. Social support and community engagement
    i. Expenses to maintain personal affairs
b. Nursing Care
    i. Nursing care consumables
c. Nutrition
    i. Nutrition supports
d. Transport
    i. Indirect transport
e. Home maintenance and repairs
    i. Expenses for home maintenance and repairs

3.3.1.3 DBR-PIA-1.3 Services Australia maintains service delivery data

Description:

Services Australia to maintain service delivery data, so that there is visibility and accountability on the services being delivered.

Business rules:

BR1. Providers may submit a claim with Services Australia daily. Providers have up to 60 days after the end of a quarter to finalise claims for ongoing services delivered in that quarter.

BR2. Services Australia is required to manage and maintain the service delivery data based on the provider's claim submissions.

Note: There will be further information about the transitional HCP group and grandfathering.

3.3.1.4 DBR-PIA-1.4 Services Australia maintains participant and provider funding data

Description:

Services Australia to maintain participant funding data, so that participants and providers have visibility over remaining funding amounts, and funding expenditure does not exceed allocated funding.

Business rules:

BR1. Services Australia will maintain the funding allocation for each participant.

BR2. Participant funding data that will be collected and maintained includes:

- the price charged by the provider for the service delivered
- the budget from which the service was funded
- the amount of participant contribution for the service being claimed for.

BR3. A participant's available quarterly balance is calculated by subtracting the services delivered from the total quarterly budget.

BR4. Participant funding data to be calculated includes:

- the total amount of funding a participant has spent (including on each type of service), for each different funding allocation, in the quarter and historically, at a point in time
- the total amount of funding a participant has remaining to spend, for each different funding allocation, in the quarter. For example, if the participant is allocated additional funding to cover assistive technology and home modifications, Short Term Restorative Care, etc.

BR5. Provider funding data to be calculated includes:

- the total amount of funding the provider has spent from each funding source they have access to, in the quarter and historically
- the total amount of funding the provider has remaining to spend from each funding source they have access to, in the quarter.

3.3.2 HL-PIA-2 Claim subsidy payment

Description

Provider to submit payment in arrears subsidy payment claims, with a supporting itemised invoice to Services Australia, on a more frequent basis for services provided to participants under the Support at Home program.

Business value

Subsidy-based services delivered under the Support at Home program will be paid on a payment in arrears basis. Providers will be able to issue a claim for payment to Services Australia on a 60-day period, or more frequent basis, for the services they have delivered to their participants. This also includes short-term support services managed on payment in arrears basis.

Providers can only bill for service types in a participant's Notice of Decision that are approved and agreed with the participant through their services agreement, supported by an itemised invoice outlining the details of these services. Prices charged must adhere to the agreed prices in the service agreement.

Providers will specify the funding source they are claiming against (such as Participant Budget, Care Management Account, or the AT-HM Budget) in their claim to Services Australia for a specific service delivered to a participant. Services Australia will validate the claim and manage payments.

3.3.2.1 DBR-PIA-2.1 Provider claim subsidy payment

Description:

Providers to submit itemised invoices to Services Australia regarding the Support at Home services that have been delivered, so that they can be paid.

Business rules:

BR1. Providers are required to issue a claim for payment at any time, at least once in a 60-day period, post the quarter ending, for the delivered services.

BR2. Providers will have the ability to confirm and acknowledge the service that was provided and record supporting documentation.

BR3. Services Australia can process the subsidy claim and use the Reserve Bank of Australia to process the payment request and organise the subsidy payment amount to the provider.

3.3.3 HL-PIA-3 Receive subsidy payment

Description

Providers to receive payment for the subsidy-based services delivered as per the itemised payment claim to Services Australia.

Business value

Once the itemised invoice, issued by a provider to Services Australia, has been successfully validated, the appropriate Commonwealth subsidy amount will be paid to the provider.

The payment amount that a provider receives for subsidised services they have delivered to a participant under the Support at Home program will need to be adjusted, to subtract the participant contribution amount for that participant for each service type detailed in the provider's itemised invoice.

3.3.3.1 DBR-PIA-3.1 Provider receives payment for services delivered

Description:

Providers to receive payment for the subsidy-based services delivered as per the itemised payment claim to Services Australia, so that they are paid.

Business rules:

BR1. Claims submitted online to Services Australia are expected to be approved and payments made within 7 days of the claim processing timeframe, as per the existing model.

BR2. Services Australia to process the subsidy claim and determine the participant contribution for each participant. Reserve Bank of Australia to process the payment request and organise the subsidy payment amount to the provider.

3.4 Care management account

3.4.1 HL-CMF-1 Manage care management account

Description

Services Australia to validate, calculate, pay, and maintain care management accounts.

Business value

A separate care management account which providers are paid from on a payment in arrears basis.

Older people in Support at Home will have 10% of their ongoing quarterly budget quarantined for care management. This funding will be retained and redistributed to providers, based on the participants in their care.

Providers will have a notional care management account, which is credited at the start of every quarter. They claim against the credits in the account.

Services Australia will manage the provider's care management account, including establishing the account, calculating credits made, and payments made to the provider. Upon receiving the claim, Services Australia will validate and manage payments.

When claiming from the care management account, a Provider needs to be registered to provide the care management services.

3.4.1.1 DBR-CMF-1.1 Services Australia to maintain providers' care management accounts

Description:

Services Australia to establish, pay, and maintain providers' care management accounts, so that the payment can be processed against those, when appropriate.

Business rules:

BR1. Services Australia is responsible for establishing a care management account for each provider.

BR2. Services Australia is responsible for calculating and updating the Care Management account. The calculation should occur on the last day of every quarter (triggered at the latest feasible time as possible e.g. 17:00 AEST). This fund is credited at the start of the next quarter (on the earliest feasible time e.g. 09:00 AEST).

BR3. If a participant's quarterly budget changes, then care management credits will be adjusted on a pro-rata basis, from the effective date of the new ongoing classification or consumer price index (CPI) change, to the end of the quarter.

BR4. The provider will not be credited for participants where the participant entry notifications are not received by Services Australia, prior to the calculation of the care management credits.

BR5. The care management credits and debits are determined by the calculations shown in Table 5, Services Australia pays the amount debited to the provider for the care management services it delivers on a payment in arrears basis.

Table 5: Care management calculation

Care management quarterly credits = (Care management base daily rate + care management supplement daily rate for each applicable participant) times by number of days in the quarter.

Care management base daily rate = 10% of annual ongoing classification amount divided by number of days in the financial year i.e. excludes all participant supplements.

Care management supplement = 12 hours of home support care management service per financial year.

Care management supplement daily rate = ($120 hourly rate multiply 12 hours) divided by number of days in the financial year

Care management debits to service provider = Service daily rate times units delivered to the participant in the quarter.

Note: The 10% care management allocated from the quarterly budget will only be once per quarter, irrespective of participant moving to another provider.

The care management base daily rate is expected to be equal to the base provider amount in the Aged Care Act Rules

BR6. The care management supplement would be applied for participants with certain diverse needs and/or vulnerabilities on an ongoing basis.

BR7. Services Australia will use the participant's characteristics sent in the care approval to calculate the care management supplement.

BR8. Care management supplements will be funded from program costs and will not be drawn from the participant's budget but will be credited to the same care management account of the provider.

BR9. Where a participant has more than one characteristic eligible for the care management supplement, the care management supplement is only applied once.

Table 6: Care management characteristics

Characteristics	Funding amount (hours per year)
First Nations	12
Homeless (or at risk of homelessness)	
Care leavers: the participant is a care leaver, that is, a participant who has spent time in institutional care or out of home care (such as orphanages and foster care), and includes a participant who is a Forgotten Australian, a former child migrant or a member of the Stolen Generations	
Veterans approved for the primary person-centred Veteran's supplement. This characteristic will be determined by Services Australia for participants having the following criteria: • be a veteran • have a mental health condition that the Department of Veterans' Affairs (DVA) accepts is related to their service.	
Referred from the care finders' program	

BR10. The provider must submit new or transferred participant details to Services Australia by the end of the last day of the quarter so that Services Australia can determine the amount credited to the care management account for the next quarter.

Care management account setup for established service providers:

BR11. For new participants entering the provider or existing participants transferred to the provider, the provider must submit the entry details of the participants to Services Australia by the end of the last day of the quarter. Services Australia will then determine the amount credited to the care management account for the following quarter.

a. For new participants entering the established provider:

i. Care management will not be credited to the provider for the notification quarter.

ii. Care management amount will be credited to the provider care management account at the start of the next quarter.

b. For existing participants moving to an established provider:

i. No care management credits are given to the gaining provider for the notification quarter (they remain with the losing provider)

ii. Care management credits start at the beginning of the next quarter.

c. A transitioned service provider will be deemed an established provider from program commencement, i.e. they will not receive pro-rata care management credits for the notification quarter for new participants or existing participants moving to the transitioned provider.

Care management account setup for new providers:

BR12. When a new provider is established, care management account credits for participants entering the service provider, are calculated and credited on a pro rata basis for the first and second quarters of operation:

a. Where the first quarter of operation for the provider is determined from the earliest participant entry notification date.

Example: Providers start date is the start of Q1. Services Australia receives first participant entry notification for Joe in Q2 with participant entry date in Q2. Services Australia receives subsequent participant entry notification for Sara in Q2 with participant entry date in Q1. So Q2 becomes the first quarter of operation because Joe's notification date is the earliest (date the notification is received by Services Australia).

b. The care management amount will be credited by Services Australia to the care management account as soon as a participant entry notification is made, on a pro-rata basis from the notification date to the end of the second quarter of operation.

i. For an existing participant moving to the newly established service provider, the care management credits are funded from the program appropriation and must not be drawn from the quarterly budget. The care management credited to the previous service provider will remain in their care management account.

Note:

- For individuals with an entry notification in the first quarter of operation, a pro-rata amount for the first quarter of operation will apply and credit for the second quarter of operation will apply at the start of the second quarter.
- For individuals with an entry notification in the second quarter of operation, a pro-rata amount will apply till the end of the second quarter of operation.

a. From third quarter onwards, the service provider will not be considered newly established service provider and BR12 will apply.

BR13. A provider's care management account will not reset each quarter and can roll over, with the rollover amount capped between financial years. However, new providers starting in the third or fourth financial quarters will not have a cap on the rollover amount carried into the next financial year.

Decommissioning of a provider:

BR14. A decommissioned provider which is not transferred or merged with another provider, will have until the agreed upon decommission date to make final claims against the care management account. Following the decommission date, the care management account is reduced to zero and the account should be closed.

Merge of providers under the same registered provider:

BR15. When a provider is merged with another provider under the same registered provider, care management remaining balance will also be transferred to the destination provider on the agreed merge date.

BR16. All claims to be finalised before the merge for both the source and destination providers.

BR17. Source provider will be decommissioned on the merge date and Services Australia will close the source provider's care management account unless otherwise agreed by Services Australia.

Transfer of a provider to a different provider:

BR18. When a provider is transferred to a different provider, the care management balance will be maintained on transfer of ownership.

BR19. All claims to be finalised before the transfer is completed.

3.4.1.2 DBR-CMF-1.2 Unspent care management credits

Description:

Providers delivering care management services are able to accumulate care management credits between quarters and into the next financial year, so they can use the care management credits in a flexible manner.

Business rules:

BR1. A provider's unspent care management credits are carried over to the next quarter (with no limit) within a single financial year.

Unspent care management credits for providers can be carried over to the next financial year, but the rollover amount is capped at the value of their

fourth-quarter allocation. However, new providers who began operations in the third or fourth financial quarters can carry over all their unspent credits without any cap. For example:

New provider

Example 1:

A new provider started operation in Q3 FY2025/26 (earliest participant entry in Q3). The provider was allocated a total of $1,000 care management credits the remainder of Q3 of FY2025/26 and $3,500 care management credits over Q4 of FY2025/26 under a pro-rata approach. At the end of FY2025/26, they have $3,000 of remaining care management credits that may consist of:

- Q4 care management leftover credits
- Care management rolled over amount from Q3

In Q1 for FY 2026/27, the provider is allowed to carry over the entire leftover care management amount of $3,000.

Example 2:

A new provider started operation in Q4 FY2025/26 (earliest participant entry in Q4). The provider received pro-rata care management credits for each participant entry in Q4 of FY2025/26. At the end of FY2025/26, they have $2,000 of leftover care management amount.

In Q1 for FY 2026/27, the provider is allowed to carry over the entire leftover care management amount of $2,000.

Established provider

Example 1:

A provider was allocated $2,500 care management credits at the start of Q4 of FY2025/26. At the end of FY2025/26, a provider has $2,000 of leftover care management credits which may consist of:

- Q4 care management leftover credits
- Care management rolled over amount from Q3

In Q1 for FY 2026/27, the provider is able to carry over the $2,000 with nothing remaining to returned, as it is less than the care management credits they were allocated at the start of Q4 FY2025/26. In other words, they can carry over a maximum of up to the Q4 credit management allocation.

Example 2:

A provider was allocated $2,500 care management credits at the start of Q4 of FY2026/27. At the end of FY2026/27, a provider has $3,000 of leftover care management funds (e.g. due to the contribution of care management rolled over amount from Q3).

In Q1 for FY 2027/28, the provider carries over $2,500 with the remaining $500 returned to the government, as they were funded only $2,500 in Q4 for FY2026/27.

BR2. Carried over unspent care management credits are subject to the same care management business rules as non-carried over care management credits.

BR3. The rolled over funds from the previous financial year won't be accessible to the provider until they finalise claims for the previous financial year, up to day 60 after the previous financial year. The provider would require a mechanism to indicate a final care management claim for the end of the financial year. Rollover from the previous financial year would happen once the provider indicates their final claim, up to day 60 of the current financial year. Otherwise, rollover to occur at the end of day 60 of the current financial year if no final claim was indicated.

3.4.2 HL-CMF-2 Claim against care management accounts

Description

Providers delivering care management services are able to claim from their care management account from Services Australia.

Business value

Providers will specify the funding source (care management account) in their claim to Services Australia for care management service delivered to a participant.

3.4.2.1 DBR-CMF-2.1 Provider submits claim for payment from care management account

Description:

Providers delivering care management services can claim from the care management account managed by Services Australia so that they can be paid.

Business rules:

BR1. Providers would bill for care management services delivered during the quarter on a payment in arrears basis against their care management account.

BR2. The budget type identifier to denote the care management claim is as follows:

- Care canagement account

BR3. The care management account can only be used by providers for care management services.

BR4. When claiming for the care management services, a provider needs to be registered to provide the care management service types.

BR5. Claims would be linked to individual participant IDs for data linkage and data governance.

BR6. Providers should not claim against the care management account for care management services provided for Restorative Care or End-of-Life classifications.

BR7. A claim for care management will be subject to the same validation rules as all other claims.

3.5 Participant unspent budget

3.5.1 HL-CUB-1 Manage participant's unspent budget

Description

Services Australia to manage and maintain participants' unspent budget.

Business value

Services Australia will manage participant's unspent budget and the associated business rules.

The Support at Home funding model provides a quarterly budget to a participant aligned to their Support at Home classification level. Providers invoice against these budgets for services delivered. At the end of a quarter, a participant is able to accrue unspent budget funds that have not been used, up to a pre-defined cap, $1,000 or 10%, whichever is higher.

Participants will receive a budget for their Support at Home classification. The budget is reset quarterly, with a cap of $1,000 in savings between quarters. For example, a participant has a budget of $5,000 per quarter. They spend $4,000 on services in the first quarter. Their budget in the second quarter is $5,000 + savings of $1,000 = $6,000. They spend $4,000 in the second quarter. Their budget in the third quarter does not go up again – savings are capped at $1,000, giving them a budget of $6,000. They spend $6,000 in the third quarter so the budget returns to $5,000 in the fourth quarter.

Unspent budget that is added to the participant's primary budget is subject to the same rules as the rest of the primary budget.

3.5.1.1 DBR-CUB-1.1 Services Australia managing participant's unspent budget

Description:

Services Australia to manage and maintain participant's unspent budget, so the payment can be processed when appropriate.

Business rules:

BR1. At the end of a quarter, a participant will be able to accrue unspent budget funds up to a set amount. The unspent budget funds will be added into the participant's next quarterly budget.

BR2. Unspent budgets are the total amount of subsidy that has not been spent on their ongoing classification.

BR3. Unspent budget would be calculated separately from the classification. This funding is quarantined and can only be used when a participant exhausts their quarterly budget.

BR4. Unspent amounts accrued in Support at Home are created and maintained by Services Australia for each care recipient.

BR5. A provider should utilise all the allocated funds for a given quarter before they can access unspent budget.

BR6. All claims for a given quarter should be finalised before the calculation of the balance of the accrued funds budget can occur.

BR7. Services Australia will calculate the accrued unspent budget a day after a provider submits their final claim (prior to day 61). The provider cannot access unspent budget until Services Australia has calculated the balance. (No further variations can be made once a provider submits their final claim (prior to day 61).

- If a provider is approved for an exceptions process after calculation of the accrued funds, Services Australia will recalculate the accrued funds amount, and either issue a debt collection notice or allocate extra funds to the participant's quarterly budget once the exceptions process has concluded.

BR8. Unspent budget will be generated after the final claim from the previous quarter is submitted and processed by Services Australia.

BR9. A participant accrues unspent budget on a quarterly basis with the amount determined as the highest of the two options below:

a. 10% (variable percentage) of the full classification amount for the full quarter plus primary supplements from when they would apply i.e. [Participant's daily rate times number of days in the quarter + care management base daily rate times number of days in the quarter + each primary supplement times number of days the individual was eligible for the supplement

b. **Note:** Each primary supplement has different eligibility criteria

i. If a participant's classification amount changes mid-quarter, the participant's daily rate and care management base daily rate applicable on the day the rollover amount is credited should be used. **OR**

c. A variable capped amount, (i.e. $1,000).

i. Once this amount is reached, any remaining funds at the end of the quarter cannot be accrued and is returned to Services Australia.

Example: If a participant on Support at Home classification 5 in January moves up to Support at Home classification 7 in February, the Support at Home classification 7 amount will be used when calculating the unspent budget for January to March quarter.

BR10. Unspent budget funds are subject to the same rules as the rest of the participant's budget.

3.6 Individual contribution

Reforms to participant contribution arrangements will apply in the Support at Home program so that:

- where their means require it, participants make a contribution to the cost of services. This will be paid directly to the provider based on the services that have been delivered
- participant contribution rates are determined by either an income and asset test or age pension status of the participant, with maximum rate pensioners paying low contributions and non-pensioners (who do not hold a Commonwealth Seniors Health Card) paying more
- contribution rates will also vary depending on the type of service that is used, with clinical supports (e.g. nursing) being fully subsidised, supports for independence (e.g. personal care) and assistive technology or home modifications attracting a moderate contribution, and supports for everyday living (e.g. domestic assistance) attracting higher contributions.

3.6.1 HL-CCS-1 Calculate participant contribution amount

Description

Services Australia to calculate participant contribution percentage, based on their income and assets to determine participant contribution amount.

Business value

The Support at Home service list will define participant contribution amounts for Support at Home services.

Rates of contributions will differ based on the service list:

- clinical support services – no contribution
- independence – medium contributions
- everyday living services – higher contributions.

AT-HM scheme participant contributions are set at equivalent rates to Support at Home categories. However, only prescription and clinical wraparound services attract the Support at Home 'clinical' category rate as per the following breakdown:

- prescriptions – 'clinical' category
- items - the 'independence' category
- wraparound services - 'clinical' category.

Services Australia calculates a participant's contribution percentage based on their pension status or income and assets assessment outcome.

Contributions are on a payment in arrears basis and only payable when services are used.

Services Australia determines participant contribution levels and notify the participant, outlining how much they will contribute towards the cost of each service in their support plan.

Services Australia re-calculates participant contribution amounts when required to ensure the participant has up-to-date information regarding the amount they contribute towards their care. This may occur when the participant's financial circumstances change or there are changes to their pension status, CSHC status or income and asset levels.

3.6.1.1 DBR-CCS-1.1 Services Australia calculates the amount of participant contribution per service

Description:

The participant's contribution amount is calculated so that the appropriate payment is paid by the participant to the provider for their aged care services.

Business rules:

BR1. Participant contributions are charged based on services that are used by the participant and their income and assets assessment class.

Table 7: Pension status

Status	Definition
Full pensioner	a) The age pension is payable for the relevant day and the pension rate is the maximum payment rate of the age pension
	b) Services Australia has worked out the participant's total assessable income and value of assets and has assessed the participant as having means that would make them eligible for the maximum rate of the age pension under the income and assets test
	c) The participant does not receive the age pension, and they are a current means tested ISP recipient (e.g. disability support pensioner) with a maximum payment rate of any means tested ISP.
Part-pensioner	a) The age pension is payable for the relevant day and the pension rate is less than the maximum payment rate of the age pension
	b) Services Australia has worked out the participant's total assessable income and value of assets and has assessed the participant as having means that would make them eligible for a part pension
	c) The participant does not receive the age pension; and they are a current means tested ISP recipient (e.g. disability support pensioner) receiving less than (but greater than zero) of the maximum payment rate of any means tested ISP

Status	Definition
Self-funded retiree who hold a Commonwealth Seniors Health Card (CSHC)	a) The age pension is not payable to the participant for the relevant day and they hold a CSHC on any day in the fortnight the day is in
	b) Services Australia has worked out the participant's total assessable income and value of assets and has assessed the participant as having means that would make them eligible for the CSHC
Full self-funded retirees without a CSHC)	a) The participant is not eligible for the age pension on the relevant day under the specified section and is neither holds nor eligible for a CHSC during any day in the fortnight, as they are not means-tested

BR2. All new participants to the Support at Home program will pay the following individual contributions from 1 November 2025:

Table 8: Support at Home individual contribution categories and rates

Means	Clinical	Independence	Everyday living
Full pensioners	0%	5%	17.5%
Part-pensioners or CSHC self-funded retirees	0%	between 5% and 50% depending on income and asset test	between 17.5% and 80% depending on income and asset test
Fully self-funded retirees	0%	50%	80%

BR3. Participant contributions will be capped at $133,122.27 (indexed) across Support at Home and non-clinical care contributions in residential care. Participants will pay zero in contributions after reaching that cap.

BR4. Part pensioners and self-funded retirees who hold a CSHC or have an income that would make them eligible for a CSHC, will undergo an income and assets assessment (whichever is greater) to determine participant contributions. A calculation of the participant contribution rate will occur for services received under the 'independence and everyday living' category. These will be known as the 'independence rate income and assets assessment' and the 'everyday living rate income and assets assessment'.

BR5. The method for calculating the participant contribution rate for the 'independence rate income and assets assessment' and the 'everyday living rate income and assets assessment' is as follows:

Step 1: Calculate the income reduction amount

- calculate the participant's total annual assessable income
- subtract the **income free area** from the participant's income. The income free area is currently determined by the ordinary income test for the pension. See the current amounts and amend each year for indexation. The current amounts are[1]:
    - $5,668* per year for singles
    - $9,880 per year for couples.
- apply the 50% reduction to the remaining amount to get the **income reduction amount**. The income reduction amount is to be rounded to the nearest dollar.

Step 2: Calculate the assets reduction amount

- calculate the participant's total assets
- subtract the **assets free area** from the total assets. The assets free area is currently determined by the assets test applicable to full pensioners[2]

Table 9: Asset test amounts

Status	Homeowner	Non-homeowner
Single	$321,500	$579,500
A couple, combined	$481,500	$739,500
A couple, separated due to illness, combined	$481,500	$739,500

- Apply a 7.8% reduction to the remaining amount, to calculate the assets reduction amount. This percentage is derived from the annual pension assets test formula of 19.5/250. The assets reduction amount is to be rounded to the nearest dollar.

[1] Income test, Services Australia, Australian Government, Income test for Age Pension - Age Pension - Services Australia.
[2] Assets test, Services Australia, Australian Government, https://www.servicesaustralia.gov.au/assets-test-for-age-pension?context=22526

Step 3: Determine the maximum reduction amount

- determine the maximum income limit. The maximum income limit is the maximum income level at which the income and assets assessment applies for the Commonwealth Seniors Health Card.

  Currently the annual amounts are*:

  - single - $99,025
  - couples - $158,440
  - couples separated by illness, respite care, or prison - $198,050[3]

  And the current income free areas are:

  - $5,668 per annum for singles; and
  - $9,880 per annum for couples.

- calculate the maximum reduction amount using the formula:

Maximum reduction amount = (**Maximum income limit** [per annum] − i**ncome free area**) × 0.50

Note: The maximum reduction amount is to be rounded to the nearest dollar.

Step 4: Compare income and assets reduction amounts

- compare the income reduction amount and the assets reduction amount
- apply the greater value of the two amounts to determine the **individual reduction amount** for Step 5.

Step 5: Calculate the input contribution rate

- compare the individual reduction amount (from Step 4) to the maximum reduction amount (from Step 3) and calculate the **input contribution rate** by finding the percentage of the individual's reduction amount relative to the maximum reduction amount.

Note: this amount is not to be rounded.

Step 6: Calculate the income and assets tested percentage contribution

- apply the input contribution rate to the following range for independence and everyday living supports to calculate the **income and assets tested percentage contribution**:
  - for independence supports, the income and assets tested percentage contribution will be applicable between the range of 5% and 50%.

    Independence rate = **the lowest rate** + **(input contribution rate** × **difference between highest and lowest range)**

[3] Income test, Services Australia, Australian Government, https://www.servicesaustralia.gov.au/income-test-for-commonwealth-seniors-health-card?context=21966

Note: if the independence rate is calculated to be below 5% (although the calculation has been designed to prevent this from occurring), the rate will be determined to be 5%. Similarly, if the rate is calculated to be above 50%, the rate will be determined to be 50%.

Note: this amount is to be rounded to two decimal points.

- for everyday living supports, the income and assets tested percentage contribution will be applicable between the range of 17.5% and 80%.

  Everyday living rate = the lowest rate + (input contribution rate × difference between highest and lowest range)

Note: if the everyday living rate is calculated to be below 17.5% (although the calculation has been designed to prevent this from occurring), the rate will be determined to be 17.5%. Similarly, if the rate is calculated to be above 80%, the rate will be determined to be 80%.

Note: this amount is to be rounded to two decimal points.

Step 7: Apply the income and assets tested percentage contribution

- Apply the calculated income and assets tested percentage contribution to the cost of independence and everyday living supports to determine the participant's contribution.

Table 10: Participant contribution calculation example

Process	Step	Example	
1. Calculate the income reduction amount	Determine participant's (Brett's) annual income:	a)	Brett is single and earns $26,000 annually from his income and receives a part-pension of $18,779.80 per annum
		b)	Total annual assessable income: $26,000
	Subtract the income free area:	c)	The income free area is the amount of income that is not counted in the income and assets assessment. This is $5,668 per annum
		d)	Remaining income after free area: $26,000 - $5,668 = $20,332
	Apply the 50% reduction:	e)	The income and assets assessment reduces the remaining income by 50% to calculate the income reduction amount
		f)	Income reduction amount: $20,332 × 0.50 = $10,166 annually

Process	Step	Example	
2. Calculate the assets reduction amount	Determine Brett's total assessable assets:	a)	Brett has assessable assets worth $350,000
	Subtract the asset free area:	b)	The asset free area is the amount of assets that are not counted in the income and assets assessment. This is $321,500
		c)	Remaining assets after free area: $350,000 - $321,500 = $28,500
	Apply the 7.8% reduction:	d)	Multiply the remaining assets after free area by 7.8% to calculate the assets reduction amount
		e)	Assets reduction amount: $28,500 × 0.078 = $2,223
3. Determine the maximum reduction amount	Maximum income limit:	a)	The maximum income limit for Brett is $99,025.
	Calculate the maximum reduction amount:	b)	The formula for the maximum reduction amount is: Maximum reduction amount = ($99,025 - $5,668) x 0.50
		c)	Maximum reduction amount: $93,357 x 0.50 = $46,679
4. Compare income and assets reduction amounts	Compare the income reduction amount ($10,244) and the assets reduction amount ($2,808):	a)	The higher amount is used for further calculations: • Income reduction amount: $10,166 • Asset reduction amount: $2,223
		b)	In this case, the individual reduction amount is the higher income reduction amount of $10,166
5. Calculate the income and assets	Take Brett’s higher reduction amount:	a)	Brett’s reduction amount is $10,166

Process	Step	Example	
tested percentage contribution	Compare it to the maximum reduction amount:	b)	The maximum reduction amount is $46,679
	Calculate the income and assets tested percentage contribution:	c)	The percentage contribution is calculated by finding the percentage of Brett's reduction amount relative to the maximum reduction amount
		d)	Income and assets tested percentage: $10,166 / $46,679 = 21.77852995993916% (This will be truncated to 2 decimal places for the next steps)
6. Apply the income and assets tested percentage contribution	Apply the calculated income and assets tested percentage contribution:	a)	For independence services, the contribution rate ranges from 5% to 50%
		b)	For everyday living supports, the contribution rate ranges from 17.5% to 80%
	Calculate the final contributions:	c)	Independence: 5% (the lowest rate) + 21.77% (input contribution rate) × (50% − 5%) (difference between highest and lowest range) = 5% + 9.79% = 14.79%
		d)	Everyday living: 17.5% (the lowest rate) + 21.77% (input contribution rate) × (80% - 17.5%) (difference between highest and lowest range) = 17.5% + 13.60% = 31.10%
Final contributions	**Independence contribution: 14.79%**		
	Everyday living contribution: 31.10%		

Changes to individual circumstances:

BR6. Changes to pension status, income and/or assets are flowed through to Support at Home and contribution rates are adjusted accordingly, with both participants and their providers receiving notification within 14 days after a decision is made by Services Australia.

BR7. A participant must notify Services Australia of the occurrence of an event or a change of circumstances where the event or change of circumstances may change their participant contribution rate, including but not limited to:

- the participant's pension or CSHC status changes under the Social Security Act
- the participant's income or assets change e.g. they sell their principal home
- the participant's partner's income or assets change
- the participant stops living with their partner
- the participant marries or starts living with their partner
- the participant's partner dies
- the participant leaves the country permanently.

BR8. A participant must notify Services Australia within 14 days after the day on which the event or change of circumstances has occurred.

BR9. The manner in which a participant must notify Services Australia of an event, or any change of circumstances is through their Services Australia account. Alternatively, the participant can notify Services Australia using:

- the Express Plus Centrelink mobile app
- the Centrelink phone self-service
- the Older Australians line - 132 300
- any other preferred method of communication.

BR10. Where a participant fails to notify of the occurrence of an event or a change of circumstances and they should have been paying a higher individual contribution rate, Services Australia will have the discretion to backdate the contribution rate to the date Services Australia is notified of the event or change of circumstance.

BR11. An adjustment will be applied in the next claim, and the subsidy paid for that participant in the next claim would be reduced by the backdated adjustment amount.

BR12. If the adjustment amount and the participant contribution is greater than the amount of the first claim that the backdated adjustment amount is applied to, this would result in the adjustment being applied to the next claim and so on, until the adjustment amount has been entirely paid by the participant.

BR13. Where a participant fails to notify of an event or a change of circumstances and they should have been paying a lower contribution rate, Services Australia will have the discretion to backdate the contribution rate to the date Services Australia is notified of an event or change of circumstance.

BR14. The provider must refund the difference to the participant on the day that the retrospective determination takes effect.

Participant contribution applied to AT-HM scheme:

BR15. Participants will contribute to the costs of their AT-HM scheme at rates equivalent to the Support at Home categories.

- For both assistive technology and home modifications, prescriptions and wraparound support services will attract the Support at Home 'clinical' category rates. This means all participants will contribute 0% to these services.
- AT-HM scheme items (including materials and labour costs) will attract the Support at Home 'independence' category rate. This means:
  - full pensioners will contribute 5%
  - self-funded retirees will contribute 50%
  - part-pensioners and CSHC holders will contribute the rate as determined through the 'independence rate income and assets test' (as per the method prescribed for Support at Home), between 5 and 50%.

Table 11: Contribution rates for new Support at Home AT-HM participants when purchasing items

Cohort	Item and modifications	Prescription and clinical support services
Full pensioner	5%	0%
Part-pensioner and CSHC holders	Between 5% and 50% depending on income and assets	0%
Self-funded retirees	50%	0%

BR16. Participants accessing high tier home modifications will pay 100% of the costs incurred above their funding allocation (funding tier + supplements if eligible).

BR17. Where a participant has been assigned a home modification high tier and has been determined to reside in MMM 6 or 7, the amount the contribution rate is multiplied by is 66.6% of the cost of the service, i.e. contribution is reduced by 33.3%.

The following formula applies: *Home modification contribution payable = (home modification claimed cost - contribution reduction)*

Example:

Mary lives in a MMM 6-7 location. She is assigned to a home modification high tier which means she has access to $15,000 in funding. Mary is also allocated a rural/remote supplement worth an additional 50% of her tier value, so has an additional $7,500 available. Mary receives 150% of the funding for an older person who does not attract the supplements. In

theory, her costs are 50% higher, so the amount she contributes (actual cost of works completed, as invoiced by the supplier) would be reduced by one third.

Note: The MMM categories and the percentage of home modification cost that the participant contribution applies to are subject to change. This will be linked to the rural/remote supplements which are also under consideration. We will provide further instructions if these details change.

BR18. Lifetime contribution cap - Participant contributions are capped at $133,122.27. Participant contributions for AT-HM scheme items contribute to this cap. Participants will pay 0% in contributions after reaching this cap.

BR19. Loaned AT items - Loaned items will attract reduced contributions. A participant's contribution rate will apply to only 33% of the total loaned AT cost.

Example:

AT loaned item cost $100 and participant contribution rate is 20%

33% of $100 is $33.33 meaning participant should pay 20% of $33 dollars = $6.67

Participant contribution = $6.67

Government subsidy = $93.33

3.6.1.2 DBR-CCS-1.2 Income and assets assessment to determine participant contributions

Description:

Services Australia performs income and assets assessments for participants to determine contribution rate.

Business rules:

BR1. The method for determining a participant's income and assets assessment class may require the participant to complete an income and assets assessment through Services Australia, if:

- the participant is not a full pensioner
- the participant's income and asset details are not known because they are a:
  - non-income and assets tested income support pensioner – permanently blind (assets and income not required)
  - not an income support payment (ISP) recipient.

BR2. The calculation of a participant's total assessable income and total value of their assets remains in force until a variation or revocation of a participant's contribution rate determination.

BR3. The income and assets assessment will align with the income test and asset test of the age pension, without other considerations such as age, or receipt of the age pension itself. Different asset and income levels will result in varying contribution amounts for participants, except for full pensioners.

BR4. Participants who are Victoria Cross (VC) recipients and/or former Prisoners of War (POWs) are exempt from individual contributions for life.

BR5. DVA will be responsible for the means test assessment for the following participants:

a. They have a Qualifying Service (QS) and are in receipt of a Disability Compensation Payment (DCP).

b. They are being paid an ISP by DVA.

c. They are the partner of an eligible veteran.

If assets and income are known:

BR6. If assets and income are known due to the participant receiving an ISP, the full pensioner income and assets assessment class and individual contribution rates will be applicable if:

- a participant does not receive the age pension
- they are a current means tested ISP recipient with a maximum basic rate of any means tested ISP in Table 12:

Table 12: List of income support payments (ISP)

Type
Age Pension
Austudy
Carer Payment
Disability Support Pension
JobSeeker Payment
Parenting Payment
Special Benefit

Type
Farm Household Allowance
Youth Allowance
Department of Veterans' Affairs Age Pension
Department of Veterans' Affairs Income Support Supplement
Department of Veterans' Affairs Service Pension

BR7. The income and assets assessment will align with the income test and asset test of the age pension, without other considerations such as age, or receipt of the age pension itself. Different asset and income levels will lead to different levels of contribution for participants other than full pensioners.

BR8. Services Australia will make a determination within a 28-day period of the individual contribution rate if assets and income are known or if assets and income have been provided.

BR9. If there is insufficient information to allow Services Australia to make a determination within the 28-day period, a Request for Further Information Notice will be issued to the participant and the income and assets assessment determination period will cease. The participant will then have 21 days to respond and:

- if they have not provided the additional information, Services Australia will determine a Means Not Disclosed status for them within 3 days of the end of the request for further information period
- if they provide sufficient information for their contribution rate to be determined, Services Australia will have a further 28 days to decide.

If assets and income are unknown:

BR10. If assets and income of a participant are unknown, Services Australia will have 46 days to decide on the contribution rate after a start notification has been given by the provider for the participant, including the ability to send a Request for Further Information Notice regarding their income and assets if no information is found. The participant will have 21 days to provide a response.

BR11. Services Australia may send a follow up notice for further information if no response is provided within the 21 days. The participant will have a further 14 days to respond.

BR12. Services Australia must determine a Means Not Disclosed status for the participant within 3 days of the end of the follow-up notice period, if they have not provided information in relation to their income and assets.

BR13. If the participant provides sufficient information for the contribution rate to be calculated, then Services Australia will have an additional 28 days to decide.

Means Not Disclosed:

BR14. A participant has a Means Not Disclosed status and will not be required to complete an income and assets assessment if:

- they are asked to provide specific information about their assets and income within a set time to help Services Australia determine their contribution rate, but fail to do so
- they elect to not disclose their assets and income.

BR15. If a participant has a Means Not Disclosed status, the 'self-funded non-CSHC holder income and assets assessment' class will be applicable to them.

BR16. A determination that a participant has a Means Not Disclosed status is a reviewable decision.

BR17. Income and assets assessment results can be reviewed at the initiation of Services Australia or upon request on the grounds that a participant:

- has other income support payments
- disagrees with the income or asset assessment made by Services Australia
- has had a change in income or asset levels.

Vary or revoke a contribution rate determination:

BR18. When giving a notice to vary or revoke a contribution rate determination, Services Australia must state in the notice that the participant may be required to notify Services Australia of any events or changes in their circumstances.

BR19. When giving a notice to vary or revoke a contribution rate determination, following certain social security decisions, Services Australia must consider whether the determination is no longer correct within 28 days of it being made aware that a relevant social security decision has been made.

BR20. Services Australia must decide to vary or revoke the contribution rate determination within 28 days of it being notified of the occurrence of an event or a change in a participant's circumstances.

BR21. If a participant has ongoing home modifications that are yet to be completed and change of circumstances or an occurrence of an event results in an increase in the contribution rate – the contribution rate that was initially calculated for the home modifications will remain in effect.

BR22. If a participant has ongoing assistive technology that has not been delivered by the provider and a change of circumstances or an occurrence of an event results in an increase in the individual contribution rate – the contribution rate that was initially calculated for the assistive technology will remain in effect.

BR23. If a participant has ongoing home modifications or has not had assistive technology delivered and a change of circumstances or an occurrence of an event results in a decrease in the individual contribution rate – the decreased contribution rate will apply from the date of effect.

3.6.2 HL-CCS-3 Submit fee reduction application

Description

Services Australia will manage and process participant's fee reduction applications to meet the requirements of the Support at Home program. This includes financial hardship, fee waiving on cultural reasons and other circumstances as specified.

Business value

A participant, their representative or provider must be able to apply for a reduction or waiving of their fees in the case of financial hardship, or if other circumstances, including cultural, make it difficult or unreasonable for them to pay their fees. In this case, he costs of their care will be subsidised.

Services Australia will be responsible for receiving, managing, and processing applications for fee reduction to determine whether a participant is eligible for a reduction or waiving of their fees. Participants eligible for fee reduction or waiving will have their contribution amounts adjusted.

If the application is successful Services Australia will update the contribution rate and the data to the provider so they are paid the new subsidy.

This would also involve updates to information and supporting business processes offered by Services Australia through shopfronts/face-to-face, phone, website, and other channels to reflect changes introduced by Support at Home.

3.6.2.1 DBR-CCS-3.1 A participant applies for a fee reduction and/or waiver

Description:

Services Australia to manage and process participant fee reduction applications that meet the requirements of the Support at Home program, so that a participant only pays what they are deemed to be able to appropriately afford.

Business rules:

BR1. A participant, their representative or their provider can apply for fee reduction when the participant is having trouble paying their contribution costs, are unable or unwilling to do so based on accepted cultural grounds, or are a member of a cohort who has been exempted from paying fees by Services Australia.

BR2. A provider may apply on behalf of a participant.

BR3. The criteria for whether an application for fee reduction is successful or not, should be in line with Service Australia's rules and practices regarding fee reduction. Rules for financial hardship should be as they are in the existing HCP program whereas rules for fee waiving on cultural or other grounds will be provided by the Department of Health, Disability and Ageing.

BR4. When a participant's fee reduction application is successful, Services Australia will update their contribution calculations.

BR5. When a participant's fee reduction application is NOT successful, Services Australia will notify the participant to ask them to confirm their current contribution with their provider.

BR6. A record of the following information regarding the fee reduction supplement should be available if needed:

- the number of fee reduction applications made
- the number of fee reduction applications approved and rejected
- the category of reason for the decision
- the minority groups such as CALD and gender
- whether any participants making applications were Aboriginal or Torres Strait Islander persons.

BR7. A fee reduction supplement may be applicable for a day for the short-term and ongoing classification types in the following circumstances:

- **financial hardship grounds** – Services Australia considers the individual paying the contribution would be caused financial hardship.

BR8. Services Australia must consider the following when determining if a participant is eligible for the fee reduction supplement and for what amount if partial or full:

- the participant's total assessable income, which will be determined either
  - if assets and income are known as they are receiving the age pension or is an ISP recipient, or
  - if the participant is required to undertake an income and assets assessment to determine their contribution rate.
- whether the amount of income available to the participant after expenditure on essential expenses is less than 15% of the basic age pension amount
- the financial arrangements of the participant
- the participant's entitlement to income support
- whether the participant has taken steps to obtain information about their entitlement to the pension, benefit or other income support payments
- whether the participant has access to financial assistance
- whether any income of the participant is income that they do not reasonably have access to
- whether there is a charge in the participant's income over which the payment of Support at Home contributions cannot practically take precedence

- whether the participant is in Australia on a temporary basis
- any other matters that Services Australia considers relevant.

BR9. Services Australia must not determine that a participant is eligible for a fee reduction supplement if:

- they have a Means Not Disclosed status; or
- the value of their total assessable assets is more than 1.5 times the sum of the annual amount of the following
  - the basic age pension amount
  - the pension supplement amount
  - the energy supplement amount.
- the individual has gifted
  - more than $10,000 in the previous 12 months, or
  - more than $30,000 in the previous 5 years.

Note: A participant's total assessable assets are known if they are receiving the age pension, are an ISP recipient, or they undertake an income and assets assessment.

BR10. Calculation of amount of fee reduction supplement

- the fee reduction supplement amount will be reduced by an amount as determined by Services Australia, i.e. either partially or fully
- Services Australia should take into consideration the eligibility in determining the amount of the fee reduction supplement applicable
- where a fee reduction supplement is applicable, the applicable fee reduction amount reduces the participant contribution amount.

Example - calculation of amount of fee reduction supplement

1. Tom has been approved for Support at Home and has been assessed into the full pensioner individual contribution rates of 5% for independence services and 17.5% for everyday living services.

2. Tom's provider makes an application for a fee reduction supplement.

3. Services Australia determines that based on Tom's circumstances, a fee reduction amount of 50% should be applied to both the independence services and everyday living services income and assets assessment categories.

4. Tom's contribution for the aged care service on that day is reduced by 50%.

Determination:

BR11. The following applies in relation to the fee reduction supplement determination:

- a participant or provider may lodge a **fee reduction supplement application** to Services Australia on behalf of a single individual or multiple individuals in an approved form

- Services Australia must make a determination regarding the fee reduction application within 28 days (**fee reduction supplement determination period**)
- if a participant is eligible for a fee reduction supplement, the fee reduction supplement is backdated from the date the determination was made to the date the fee reduction application was lodged by the individual:
    - if the application is successful and a determination is made that the participant should have been paying a lower contribution rate during the fee reduction supplement determination period, the provider must refund the difference to the individual within 28 days after the contribution rate has been set.
- Services Australia may request further information from the participant in making a determination
    - if Services Australia does request further information, the participant has 28 days to provide this (**request for further information period**)
    - if the participant does not provide further information, the fee reduction application is considered withdrawn
    - if the participant provides further evidence and Services Australia is satisfied, Services Australia has until the end of the 'request for further information period' to decide
    - if the application is successful, Services Australia will recalculate the individual contribution rate
    - if the application is unsuccessful, Services Australia will notify the participant and the provider, stating that the application was unsuccessful and the current contribution rate will remain.

BR12. A notice will contain:

- a statement that a participant may be required to notify Services Australia of any events or changes in their circumstances
- the previous contribution rate
- the reasons for the decision.

Revocation:

BR13. Services Australia may revoke a determination that a participant is eligible for a fee reduction supplement if:

- the circumstances of the participant have changed
    - the participant's circumstances may change if their assets that were unrealisable assets are no longer assets of that kind.
- Services Australia is satisfied that the contribution rate that is more than the amount specified in the determination would not cause the participant financial hardship.

Reviewable decision:

BR14. A determination by Services Australia to reject an application by a participant for a fee reduction supplement is a reviewable decision.

BR15. A decision to revoke a determination that a participant is eligible for a fee reduction supplement is a reviewable decision.

3.7 Supplements

3.7.1 HL-SUP-1 Supplements

Description

Services Australia will determine the participant's supplement eligibility and pay the supplements.

Business value

Services Australia will calculate participants' supplements.

3.7.1.1 DBR-SUP-1.1 Services Australia calculates the amount of participant supplements to be paid for each participant

Description:

Services Australia to calculate participants' supplement eligibility and payments, so that the appropriately determined rate of supplement payment is paid to the participant.

Business rules:

BR1. Services Australia assesses the eligibility of each supplement a participant has applied for.

BR2. Services Australia processes supplement payments to eligible participants.

BR3. The following supplements will be applicable to participants under Support at Home:

- enteral feeding supplement
  - enteral feeding supplement – Bolus ($21.58 daily supplement amount)
  - enteral feeding supplement – Non-bolus ($24.24 daily supplement amount)
- oxygen supplement ($13.62 daily supplement amount)
- veterans' supplement (daily supplement amount is 11.5% of the daily rate) for the participant's applicable Support at Home class 1-8.

Note: The amounts mentioned are indicative only and are subject to change.

Table 13: Payments – quarterly supplement budget calculation

Quarterly supplement budget = Daily supplement rate (differs depends on the supplements) multiplied by number of days in the quarter

BR4. All other supplements will be discontinued for participants under Support at Home. This will include grandfathered participants upon reassessment into Support at Home.

BR5. The eligibility for applicable supplements will be as per existing eligibility processes within the HCP program. This includes where a participant may be eligible for a higher rate of supplement.

BR6. For Veterans' supplement, the participant meeting requirements for the payment will be as per the existing process in place between Services Australia and DVA.

BR7. Where a participant has a current ongoing payment, supplements will be added to their quarterly budgets for that ongoing payment from the start of the quarter. If a supplement started part-way through the quarter, then it will be calculated on a pro-rata basis from the start date of the supplement to the end of the quarter.

BR8. Where a participant does not have an ongoing payment but has a Support at Home Restorative Care Pathway classification or End-of-Life classification, supplements will be added to their budget for that short term payment up to the end of the short-term allocation period. If a supplement started part-way through the allocation period, then it will be calculated on a pro-rata basis, from the start date of the supplement to the end of the allocation period.

BR9. The supplement amount is added on to the participant's budget. The provider will not claim against a supplement specifically. The increased participant budget is available for the provider to claim as per usual, including for the use of services and equipment related to supplement needs, where required.

BR10. Supplements can only be added to one payment for a participant, at any one time, i.e., A participant can NOT have a supplement added to their ongoing payment and receive the same supplement on a short-term payment, at the same time.

- if a participant has ongoing Support at Home classification budget and the Restorative Care Pathway budget, the supplement will be applied to their ongoing quarterly budget as default.

BR11. Supplement allocations will follow the participant if they leave one Support at Home provider and move to another Support at Home provider. The gaining provider will not need to reapply for the supplement.

BR12. If a supplement is end-dated, it will take effect:

- if added to an ongoing classification budget, from the end of the quarter in which it was ended.

- if added to a short-term classification budget, from the end of the allocation period in which it was ended.

BR13. If a participant leaves and later re-enters Support at Home, the supplement will be reinstated when the classification budget is reinstated, unless the provider had ended the supplement.

- If a provider had end dated a supplement, they will have to reapply for it, whether it's the same Support at Home provider or a gaining Support at Home provider.

BR14. If a participant enters another program, like residential care or respite, their supplement eligibility won’t transfer. However, it will be kept for Support at Home if they return after residential respite.

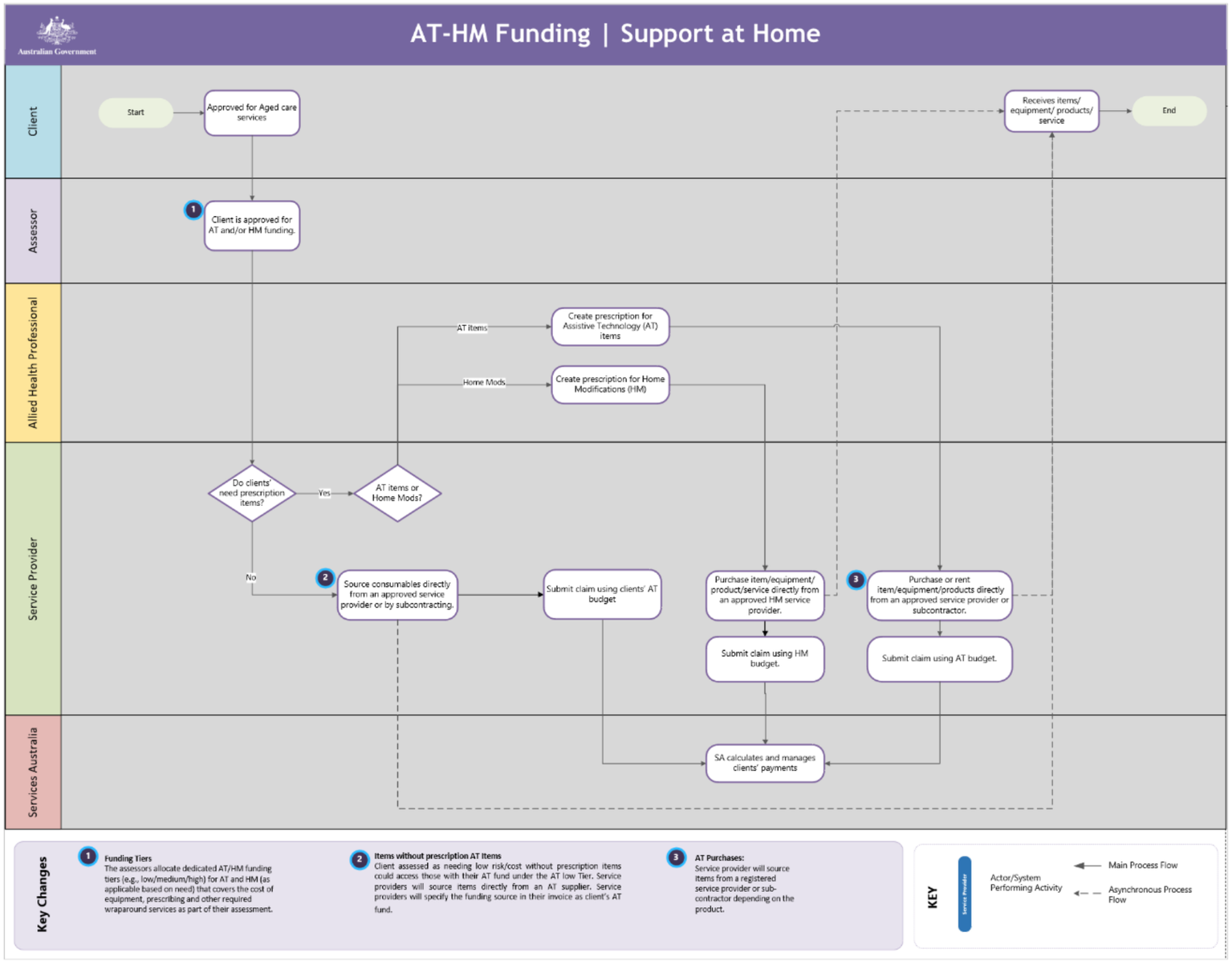
4. Payments – Short-term support

4.1 Future state business process

Providers will be responsible for arranging and sourcing the necessary AT-HM scheme services based on the participant's funding tier.

The process is illustrated in the diagram with key changes noted.

Figure 2: AT-HM process flow



4.2 Assumptions

The table below outlines the key assumptions on payments for short-term support. These are related to the Restorative Care Pathway, the End-of-Life Pathway and the AT-HM scheme.

Table 14: Payments – Short-term support assumptions

Assumptions	
1	Restorative Care Pathway providers will need to be registered to deliver Restorative Care Pathway service types.
2	Participant eligibility for the Restorative Care Pathway would be determined at an aged care assessment.
3	A new participant accessing aged care services can only receive either the Restorative Care Pathway or an ongoing allocation, not both.
4	The Restorative Care Pathway will be delivered through multi-disciplinary allied health support with a focus on clinical interventions.
5	Participants in the Restorative Care Pathway will be required to access a restorative care provider.
6	Restorative Care Pathway places will be capped at 5,000 per quarter in the first year of Support at Home. (20,000 places over 12 months).
7	The End-of-Life Pathway services would not replace the medication management services that are provided by states and territories for people who are receiving palliative care at home.
8	The End-of-Life Pathway and Restorative Care Pathway are subject to individual contributions
9	Eligibility for Support at Home is a pre-requisite for eligibility for the AT-HM scheme. Access to AT-HM funds will be needs based as determined at assessment, reflected in funding tiers and limited to AT-HM scheme items on the AT-HM list.
10	A provider will organise participant referral to an allied health professional for prescription or under advice items.
11	All AT-HM scheme services/equipment will be accessed through the participant's provider. Providers will loan/purchase AT-HM products and

Assumptions	
	services directly through AT-HM suppliers or jurisdictional loans schemes (where available through an off-system process).
12	AT-HM scheme claims may need additional validation which will be managed via the claiming guidance.

4.3 Restorative Care Pathway payments

4.3.1 HL-RCP-1 Manage Restorative Care Pathway payments

Description

Services Australia will manage participant's Restorative Care Pathway payments on a payment in arrears basis.

Business value

The funding model will be payment in arrears.

Services Australia will validate and manage payments.

A single episode of the Restorative Care Pathway lasts up to 16 weeks.

4.3.1.1 DBR-RCP-1.1 Services Australia validate and manage payments

Description:

Services Australia to validate and manage payments, so that payments can be processed, and the participant can receive Restorative Care Pathway services.

Business rules:

BR1. A provider will be able to submit a claim for the Restorative Care Pathway service/s they have provided via the Services Australia Aged Care Provider Portal.

BR2. The Restorative Care Pathway claim that has passed the validation process will result in payments for services that have been provided.

BR3. Services Australia will calculate the funding amount based on the Restorative Care Pathway fund for each participant.

BR4. Providers may only submit claims if they're registered with an eligible service group.

BR5. An episode of Restorative Care Pathway commences from the date of the participant's goal plan.

BR6. A single episode of Restorative Care Pathway lasts up to 16 weeks.

BR7. A participant can receive a maximum of two units of Restorative Care Pathway per year which can be either:

- two units/budgets, spaced out over the year via two separate episodes or,
- two units/budgets within a single episode (following assessor approval).

BR8. A participant cannot have two restorative care episodes back-to-back. Participants will need to wait for at least a quarter, post the original

restorative care episode ending before being eligible to receive another unit/budget of restorative care (maximum of 2 units per year, per participant).

BR9. Providers may request a SPR if the participant is in need of more funding (maximum of 2 units) within the same 12-week period.

BR10. A claim for the Restorative Care Pathway will use the funding source 'Restorative Care Pathway Payments' in system.

BR11. HCP unspent funds will be available for participants accessing the Restorative Care Pathway.

BR12. When their Restorative Care Pathway budget is exhausted, system to use HCP unspent funds, where available.

BR13. A claim for the Restorative Care Pathway will be subject to the same validation rules as all other claims.

BR14. To pass the claim validation process, the following information should be provided/available:

- the participant is eligible to receive services
- the provider is eligible to provide services to a participant
- a valid funding source, and for funds to be available.

BR15. To submit a claim, a provider should:

- be registered against the service group to deliver services to Support at Home participants
- be registered against the service type to deliver the service being claimed for to Support at Home participants.

BR16. A separate care management account will not be required for Restorative Care Pathway. Care management services for participants will be billed directly against their Restorative Care Pathway budget.

BR17. No cap restriction is applicable to care management funding on the Restorative Care Pathway budget.

4.4 End-of-Life Pathway

4.4.1 HL-PCP-1 Manage End-of-Life Pathway classification budget

Description

Services Australia will manage participant's End-of-Life Pathway budget.

Business value

The End-of-Life Pathway budget is its own classification.

A single episode of the End-of-Life Pathway lasts 12 weeks, with 16 weeks to use the funds to provide additional flexibility. Where participants are expected to need services beyond 12 weeks, a support plan review should be undertaken to determine the most suitable care options. Payment to providers will be paid in arrears for services delivered against the participant's budget under Support at Home.

Services Australia will manage the End-of-Life Pathway budget and the associated business rules on a payment in arrears basis.

4.4.1.1 DBR-PCP-1.1 Services Australia validate and manage payments

Description:

Services Australia to validate and manage payments, so that payments can be processed, and the participant can receive the End-of-Life Pathway services.

Business rules:

BR1. The End-of-Life Pathway services would be drawn from the Support at Home service list.

BR2. For existing Support at Home participants, they need to be upgraded from their current classification to End-of-Life Pathway classification.

BR3. Existing AT-HM participants can continue to receive their funding while they access End-of-Life Pathway.

BR4. Funds for End-of-Life Pathway services are available from the participant's End-of-Life Pathway budget, as well as any unspent HCP funds, if available.

BR5. When End-of-Life Pathway budget is exhausted, system to use HCP unspent funds, if available.

BR6. End-of-Life Pathway is a 12-week funding classification, with a duration of 16 weeks to use the funding, to provide flexibility.

BR7. If the participant requires services beyond 12 weeks, an SPR should be undertaken to determine the most suitable care options.

BR8. Service providers should submit all claims for End-of-Life Pathway services up until 60 days after the last day of the 16th week of support.

BR9. A claim for the End-of-Life Pathway services will have the funding source as ‘End-of-Life budget’.

BR10. For existing Support at Home participants, any unspent remaining budget from the ongoing quarterly budget will not be available when the participant moves to the End-of-Life Pathway classification.

BR11. A claim for the End-of-Life Pathway services will be subject to the same validation rules as all other claims.

BR12. To pass the validation process, the following information should be provided/available:

- the participant is eligible to receive services
- the provider is eligible to provide services to a participant
- a valid funding source and for funds to be available.

BR13. To submit a claim, a provider should:

- be registered against the service category to deliver services to Support at Home participants
- be registered against the service type to deliver the service being claimed for Support at Home participants.

BR14. A separate care management account will not be required for End-of-Life Pathway participants. Care management services for participants will be billed directly against their End-of-Life Pathway budget.

BR15. No cap restriction is applicable to care management funding on the End-of-Life Pathway budget.

4.5 Assistive Technology and Home Modifications (AT-HM) scheme funding

4.5.1 HL-ATP-1 Manage AT-HM scheme budget

Description

Services Australia will maintain the participant's AT-HM funds on a payment in arrears basis.

Business value

The AT-HM funding model will be payment in arrears. Any AT-HM funding allocation will be separate from the participant's quarterly budget.

Funding tiers:

Eligibility and the need for AT-HM funding will be determined at assessment. The assessor allocates dedicated AT-HM funding tiers (e.g. low/medium/high) for assistive technology and home modifications (as applicable based on need). This covers the cost of equipment, prescribing and other required wraparound services. Participants can be allocated both an assistive technology funding tier and a home modification funding tier at assessment if needed.

HCP unspent funds must be used, if available, before AT-HM funding tiers are accessed.

AT-HM supplements:

AT-HM supplements will be payable based on remoteness. The AT-HM supplement for remoteness will be based on the Modified Monash Model as applied to the participant's location. AT-HM supplements are applied over and above the participant's AT-HM funding tier. Providers may claim remote status as applicable to the participant.

Assistive technology items without prescription:

For assistive technology items that do not require a prescription, the provider will source items directly from an assistive technology supplier. Providers will specify the funding source in their invoice as participant's assistive technology fund or HCP unspent funds if available. Services Australia will validate and manage the payment.

Assistive technology items with prescription:

Providers will source the prescription from an appropriately qualified health/allied health professional. The provider will source items and any required wraparound services through purchase or loan, depending on the product. In both cases, providers will specify the funding source as participant's assistive technology fund or HCP unspent funds if available. Services Australia will validate and manage payment.

National Assistive Technology Loans Scheme:

The AT Loans Scheme is delivered by states and territory governments (e.g. Enable NSW) to provide high quality new and refurbished equipment to older people.

Providers will purchase equipment or rent it from another provider when there is no AT Loans Scheme available, or not available from the AT Loans Scheme within that region.

Assistive technology purchases and private loan/rental:

Providers will source items from an assistive technology supplier depending on the product.

Home modification services:

Providers will source and manage the prescription and items/services depending on the product. Providers will specify the funding source as participant's AT-HM funding or HCP unspent funds if available. Services Australia will calculate and determine the validity of the claim and manage payment.

4.5.1.1 DBR-ATP-1.1 Services Australia validates and manages AT-HM scheme payments

Description:

Services Australia to validate and manage payments, so that payments can be processed, and the participant can receive AT-HM funding.

Business rules:

BR1. A provider can submit a claim for AT-HM scheme service/s they have provided via the Services Australia Aged Care Provider Portal.

BR2. Participant assessed as needing assistive technology or home modification items can access those services using their AT-HM funding. Participants with HCP unspent funds must use them to access assistive technology or home modifications before accessing AT-HM funding.

BR3. Services Australia will maintain two separate assistive technology and home modifications funds for eligible participants based on the funding tiers set by Department of Health, Disability and Ageing.

BR4. Services Australia will calculate and determine the validity of the claim and manage payment.

Assistive technology:

BR5. Assistive technology (AT) funding tiers (low, medium, and high) will have an allocation period of 12 months.

AT high tier:

BR6. For AT high tier participants to access funds above $15,000, the service provider will need to provide the following additional information as part of their claim:

a. Service type/s
b. Service/s
c. Item/s description
d. Justification
e. Progressive conditions
f. Whether the item is purchased or loaned (If loaned, specify the state or territory loan scheme)
g. Declaration that the service provider has followed the Support at Home AT-HM scheme guidelines.
h. Item prescription/s
i. Quote/s
j. Invoice/s

Note: Delegate approval for the above business rule is **not** required, noting the participant has already been allocated AT high tier to align with their assessed needs.

BR7. Claims are subject to usual AT-HM claiming processes.

BR8. Services Australia will generate quarterly report summarising AT high tier payments made during the reporting period, including claim information, evidence given, and provide it to Services Australia program assurance area and the Department of Health, Disability and Ageing.

Restorative Care Pathway and AT tier allocations

BR9. Eligible Restorative Care Pathway participants can be allocated any assistive technology tier. (Funding availability follows the AT-HM scheme rules).

AT administration costs:

BR10. Assistive technology administrative costs are capped at 10% of the item/item bundle cost or up to $500 (whichever is lower).

Repairs and maintenance:

BR11. Repairs and maintenance for assistive technology are funded through a participant's initial assistive technology funding tier:

- if the assistive technology funding is insufficient, or the time period has passed, and the participant has no HCP unspent funds, there are two funding options:

- if there are ongoing Support at Home funds available, the assistive technology or home modification services on the Support at Home service list can be used; or
- where insufficient Support at Home funds are available, providers can submit a review, and the participant can be allocated to an appropriate assistive technology tier (to align with submitted quote).

BR12. For assistive technology participants transitioned from HCP to Support at Home, the above repairs/maintenance rule will apply but the item will need to be on the AT-HM list.

Specified needs:

BR13. Participant's eligible for the assistive technology specified needs category will be provided with an ongoing funding allocation.

BR14. Specified needs tiers are ongoing, annual allocations, with funding being allocated every 12 months.

BR15. A specified needs tier can be allocated either on its own or in addition to an assistive technology funding tier (low, medium, or high).

BR16. Funding allocation for specified needs will be automatically credited every 12 months.

- after the allocation period has elapsed, funding will be reset. (i.e. no rollover).
- if the participant no longer requires a specified needs funding tier, the provider will notify the System Governor (through their Services Australia Provider Account) within 14 days of this change. The participant will not receive another funding allocation after the end of the allocation period for the discontinued specified needs funding tier.
  - If the participant is NOT receiving any other assistive technology funding tier besides the discontinued specified needs funding tier (assistance dogs), any remaining funds will be returned after the claim finalisation period.

Home modifications:

BR17. Home modifications funding tiers (low, medium, and high) will have an allocation period of 12 months.

BR18. For home modifications high tier allocations, an extension can be granted for a further 12 months (total of 24 months) if home modifications progression is proven (e.g. quote/contract). Funding will not increase if extension has been granted, no SPR is required.

BR19. Participants who are eligible for high tier home modifications funding will have access to the total amount of $15,000 (+ any supplements), once per lifetime.

- If the participant did not spend the full home modifications high tier allocation amount, upon re-assessment

- If the participant is eligible, they can be re-assessed for the home modifications high tier.

When the participant is re-assessed, the high tier home modifications fund is recalculated:

> Available high tier home modifications funds **= High tier home modifications cap amount (+ supplements) – funds claimed from any previous high tier home modification allocation.**

BR20. Ability for a provider to submit one or more quotes, at the point of claiming for home modifications.

BR21. Providers will make a declaration, at the point of claiming for home modifications.

BR22. Providers may claim partial payment of home modifications linked to milestones on an ad-hoc basis for high tier home modifications. Evidence should be uploaded (types of evidence outlined in scheme guidelines).

Home modifications coordination costs:

BR23. Home modifications coordination costs are capped at 15% of the quoted cost or up to $1,500 (whichever is lower).

Home modifications repair and maintenance:

BR24. Home modifications repair and maintenance alteration costs may be funded through:

- the participant's home modifications tier funding (within the home modifications funding allocation period)
- the participant's Support at Home ongoing services budget (home modifications service type post home modifications funding allocation expiration).

AT-HM supplement:

BR25. An AT-HM supplement would be applied for participants with diverse needs and/or vulnerabilities. Refer to Table 15 - AT-HM supplements.

Table 15: AT-HM supplements

Characteristics	Supplements
Rural (Modified Monash Model 4-5)	0%
Remote/Very Remote (Modified Monash Model 6-7)	50%

BR26. AT-HM supplements are applied over and above the participant's AT-HM funding tier.

BR27. AT-HM supplements are additive.

BR28. AT-HM supplement amount will attract a participant contribution.

BR29. Services Australia will use the participant's characteristics sent in the care approval to calculate the AT-HM supplements.

Progressive conditions:

BR29. AT-HM scheme participants eligible for one or more progressive conditions will be allocated a funding tier (medium or high) at assessment to cover the progressive condition plus any additional needs of the participant.

- the allocated funding tier (medium or high) would be available for 24 months to allow the funding to be utilised
- this can be extended for a further 24 months (48 months in total) when the provider confirms ongoing/prescribed need, meaning no SPR is required
- funding will not increase if extension has been granted.

Claiming:

BR30. A claim for assistive technology will have funding source as assistive technology fund.

BR31. For assistive technology and home modifications services requiring prescriptions, providers will need to wait until the prescriptions are available before submitting a claim.

BR32. A claim for assistive technology for the participant needing low-cost items or without prescription will have funding source as participant's assistive technology budget.

BR33. A claim for home modifications (HM) for a participant needing HM with prescription will have the funding source as home modification fund.

BR34. Providers will be able to issue a claim for payment at any time, at least once in a 60-day period, post the allocation period ending, for the delivered assistive technology or home modifications items and/or services.

BR35. A claim for AT or HM will be subject to the same validation rules as all other claims.

BR36. For AT services, mandatory evidence will be required for all AT high tier claims including the prescription.

a. For claims for client's approved for AT low and medium tiers, evidence will be optional (including prescription claims).

BR37. For HM services, mandatory evidence will be required for all HM high tier claims including the prescription.

a. For claims for client's approved for HM low and medium tiers, evidence will be optional (including prescription claims).

Allocation continuance:

BR37. If the Restorative Care Pathway or the End-of-Life Pathway is allocated alongside an assistive technology and home modifications allocation, the AT-HM allocation will continue for the respective allocation period after the allocation for End-of-Life Pathway or Restorative Care Pathway has elapsed.

a. Participants must be approved for the service(s) that the claim is being made for under the relevant approved budget.

5. Transition

5.1 Assumptions

Table 16: Support at Home transition assumptions

Assumptions	
1	Participants currently receiving HCP and STRC services will receive the same funding that they are currently receiving (or are approved to access) on transition to the Support at Home program.
2	Transitioning HCP participants will have approval for all Support at Home service types including AT-HM.
3	Transitioning HCP participants will have their HCP entry notification deemed as their Support at Home entry notification.
4	To provide one or more services under Support at Home program, a service provider will need to be a registered provider for that service group and service type.
5	Information to transitioning participants and providers will be provided through standard communication channels where appropriate to reduce load on systems.
6	Home Care Providers will be deemed Support at Home providers.

5.2 Support at Home participant transition and data migration

5.2.1 HL-CTD-1 Support at Home participant transition and data migration

Description

Services Australia to ensure seamless transition of HCP and STRC care recipients to the Support at Home program.

Business value

The Support at Home program replaces the HCP Program and STRC Programme. The transition and data migration activities will support participants to continue to receive an equivalent level of care when the Support at Home program is introduced.

5.2.1.1 DBR-CTD-1.3 Transition of HCP Commonwealth Unspent funds

Description:

Services Australia to transition existing participants receiving Commonwealth HCP unspent fund to the new Support at Home program.

Business rules:

BR1. Upon the effective transition date into Support at Home (day of Support at Home program commencement), HCP Commonwealth unspent funds will no longer accumulate funds.

BR2. Home care account will be combined with HCP Commonwealth unspent funds and represented as the HCP Commonwealth unspent funds for the purposes of Support at Home.

For Services Australia held HCP unspent funds:

BR3. Services Australia held HCP unspent funds will be transferred to the Support at Home program effective on the day the program commences.

BR4. Participants will continue to be able to draw down from their HCP unspent funds for services under Support at Home until the balance reaches zero.

BR5. When a provider submits a claim, Services Australia draws down from the HCP unspent funds as per the following:

- Payment for non AT and HM services to participants will be prioritised to be claimed in the following order:
    - Participant quarterly budget
    - HCP unspent funds

- HCP unspent fund payments to participants will be prioritised for AT-HM services to be claimed in the following order:
    - HCP unspent funds
    - Participant AT-HM funding tier

BR6. A participant's HCP unspent fund account will be closed once their funds have been exhausted (balance $0).

For service provider held HCP unspent funds:

BR7. Provider held HCP unspent funds will remain with the provider and be transferred to the Support at Home program effective from program commencement through 'mandatory opt-in' under the existing auto drawdown model.

BR8. Providers will report and declare to Services Australia the final HCP unspent fund balance that they hold for each of their participants in the final claim before the Support at Home cutover as at 31 October 2025.

BR9. When a provider submits a claim that requires drawing down from the HCP unspent funds then Services Australia will deduct that amount from the opt-in balance and not pay it to the provider.

BR10. Participants will continue to be able to draw down from their HCP unspent funds for services under Support at Home until the balance reaches zero. From program commencement, when a provider submits a claim, Services Australia will draw down from the reported HCP unspent fund opt-in amount as per the following:

- Payment for non AT-HM services to participants will be prioritised to be claimed in the following order:
    - Participant quarterly budget
    - Commonwealth HCP unspent funds
- Payment for AT-HM services to participants will be prioritised to be claimed in the following order:
    - Commonwealth HCP unspent funds
    - Participant AT-HM funding tier

BR11. Services Australia will no longer draw down on a participant's HCP unspent funds once their funds have been exhausted (balance $0).

BR12. Providers will have the option to return the HCP unspent funds to Services Australia post program commencement.

5.2.1.2 DBR-CTD-1.4 Transition of HCP participants' contributions to Support at Home

Description:

Services Australia to transition existing HCP participants' individual contribution arrangements into Support at Home.

Business **r**ules:

Income and asset testing determination:

BR1. The income and asset testing capability should be configurable to apply to income only, asset only, or both, to support transitional and ongoing income and asset testing arrangements.

BR2. A calculation of the individual contribution rate will occur for services received under the independence and everyday living means testing categories. These will be known as the 'independence rate means test' and the 'everyday living rate means test'.

BR3. The method for calculating the individual contribution special rate for the 'independence rate means test' and the 'everyday living rate means test' will be the same as what is prescribed under *3.6.1.1 DBR-CCS-1.1 Services Australia calculates the amount of participant contribution per service.*

'No worse off' principle

BR4. For individual contributions, a 'no worse off' principle (NWOP) applies for HCP recipients who, on or before 12 September 2024, were either receiving a Home Care Package, on the National Priority System, or assessed as eligible for a package.

BR5. For participants eligible for the NWOP arrangement who, based on their HCP means assessment, are liable to pay an income tested care fee (ITCF) under the current system, will undergo a means test on their **income only** to determine individual contributions.

BR6. For participants who are not eligible for the NWOP arrangement, if Services Australia only has income information, Services Australia will use the income only to set an initial contribution from program commencement. Participants would then be asked for asset information and their rates updated on the basis of that information, with the new contribution rate to be applied from the following quarter.

BR7. Services Australia must ensure that participants eligible for the NWOP arrangement and liable to pay an ITCF will have a fortnightly cap applied to their contributions. This cap will be calculated by multiplying their ITCF over 365 days to determine their annual total, divided by 26 to get their fortnightly cap.

Table 1716: Example of Support at Home fortnightly contribution cap

ITCF annual total = ITCF is multiplied by 365 days in the financial year.

Support at Home fortnightly contribution cap = ITCF annual total divided by 26.

E.g. Arnold is a HCP 3 care recipient and assessed to pay a ITCF of $18.77 per day. This means Arnold's ITCF **annual cap** total on Support at Home is $6,851. This divided by the 26 fortnights will be **$263.50 per fortnight.**

Table 18: Special rates that apply to individuals in the aged care system on or pre 12 September 2024

Status	Clinical	Independence	Everyday living
Full pensioner	0%	0%	0%
Part pensioner	0%	0% - 25%	0% - 25%
Part pensioner and CSHC holders			
Full self-funded retirees	0%	25%	25%

BR8. Participants on the special rates status will remain on the arrangements for life, including if they leave Support at Home and return at a later date, even if they take the active decision to leave Support at Home.

BR9. Participants on special rates who are reassessed will still remain on the special lower rate.

BR10. Participants who have reached their lifetime cap will not pay contributions under Support at Home.

Contributions for AT-HM transition:

BR11. HCP care recipients receiving AT-HM on or prior to 12 September 2024 will remain on the $82,347.13 (as at 1 July 2025) cap when they transition to Support at Home.

BR12. HCP care recipients who do not pay fees (including full pensioners) continue to pay no fees for their HM for their full time in Support at Home

BR13. HCP care recipients (fee paying) - low contribution rates assessed for AT-HM. These participants pay low rates from program commencement and will pay for the lifetime to align with new Support at Home participants.

Cohort	Item and modification	Prescription	Wraparound services
Full pensioner	0%	0%	0%
Part pensioner and CSHC holders	Between 0% and 25% depending on income and assets	0%	0%
Self-funded retirees	25%	0%	0%

5.2.1.3 DBR-CTD-1.9 Setting up care management Accounts for transitioning HCP participants

Description:

Services Australia to set up care management accounts for providers.

Business rules:

BR1. Services Australia to establish a care management account for each provider registered to deliver care management services under Support at Home prior to program commencement date.

BR2. Services Australia to determine the care recipients receiving care through a service provider, including:

a. their classification level and;
b. if they meet eligibility criteria to enable the provider to receive the provider-based care management supplement on a day nominated by the department.

BR3. When Support at Home program commences, a transitioned HCP participant's care management quarterly credits for that quarter must be calculated and credited in providers' care management account on a pro-rata basis from program commencement date as follows:

Care management quarterly credit calculations

- Care management quarterly credits = (care management base daily rate + care management supplement daily rate for each applicable participant) times by number of days remaining in the quarter.
- Care management base daily rate = 10% of annual transitioned HCP level amount divided by number of days in the financial year (i.e. excludes all participant supplements).
- Care management supplement daily rate = ($120 hourly rate multiply 12 hours) divided by number of days in the financial year

- **Note:** The 10% care management allocated from the quarterly budget must be only once per quarter, irrespective of participant moving to another provider.
- The care management base daily rate is expected to be equal to the base provider amount in the Aged Care Rules.

BR4. The transitioned provider will be deemed an established provider from program commencement, i.e. they will not receive pro-rata care management credits for the notification quarter.

BR5. Providers seeking care management supplement funding to update Services Australia on existing participant information and send declaration to Services Australia for approval on a day nominated by the department for the following key eligibility criteria:

a. First Nations
b. homeless or risk of homelessness
c. veteran
d. care leaver
e. referred via Care Finders program

BR6. The department will send existing participant's key eligibility data to Services Australia before transition to ensure participant's receiving HCP or eligible to receive a HCP automatically receive the Support at Home care management supplement from program commencement. The key eligibility includes, but is not limited to:

a. First Nations
b. homeless or risk of homelessness
c. veteran
d. care leaver
e. referred via Care Finders program

6. Appendix A - frequently asked questions

6.1 Service delivery branch FAQs

The below table details questions and responses from the service delivery branch (SDB) slide pack.

No.	Question	Response
1	Can one NAPS Org ID have multiple NAPS Provider IDs?	No – the key change in the provider registration model under the new Act is that one organisation will have one registered provider (with a unique NAPS Provider ID). If the organisation sub-contracts services, an associated provider will be linked to the organisation, however the registered provider is where all payment entities will be linked to.
2	Can a provider have multiple service delivery branches? / Can one NAPS Provider ID have multiple NAPS Service ID (SDB)?	Yes – however, existing NAPS Service IDs will remain, and a provider is not expected to change these to accommodate the introduction of Support at Home. i.e. a provider's HCP services will become Service Delivery Branches.
3	Can one service delivery branch be linked to multiple NAPS Service ID?	No - One SDB always links to one NAPS Service ID.
4	What is the relationship between service delivery branch and outlet?	An outlet continues to be used as the entity defined to provide intake in a service delivery area. Services are only able to be added to outlets if the provider has a service delivery branch, and service configuration is restricted by registration categories.
5	Are there impacts on Outlets as part of transition?	Existing outlets in ACG will be automatically transitioned. HCP outlets will be transitioned into Support at Home outlets. Current outlet service configuration and information (e.g. pricing schedule) will be retained.

6	Are there any impacts to Outlets set up as a result of SDB?	No. Outlets and referral management functions in ACG will continue as per the current state and are not impacted by the shift to SDB terminology.
7	What do providers need to do to set service delivery branches in Health systems as part of Support at Home transition?	For existing providers, their existing NAPS Service ID will continue to be used for Services Australia claiming/payments. All existing home care services will automatically be migrated to Program Payment Entity from 1 November 2025. Providers are not required to restructure, though they may wish to review.
8	Are there any limitations on how service delivery branches can be defined, and can the Department provide guidance on how to structure them?	Service delivery branch, while a new term, is equivalent to what is called a home care service in the current state and will continue to have the same NAPS Service ID associated with it. All existing home care services will keep the same ID. There are no requirements to restructure, nor are there any limitations on the number of care recipients per Service Delivery Branch. The department does not have specific guidance on how to structure service delivery branches, in recognition of unique operational requirements of each provider.
9	What is the process for creating new service delivery branch or merging those?	As the Service Delivery Branch is equivalent to a Home Care Service in current state, the process of creating, merging and transferring services will replicate the current process. E.g. a notification form for new service delivery branches , and application form for merge or transfer submitted to the department's relevant state or territory office.
10	Does the 10% care management pool under the Aged Care Act allow providers to ring-fence it based on their own service delivery branch structure?	Yes, the pooling of care management funding - i.e. 10% of participants' quarterly budget- will occur at the service delivery branch level (NAPS Service ID).

6.2 Unspent funds FAQs

The below table details questions and responses from the unspent funds slide pack.

No.	Question	Response
1	How is Services Australia prioritising/sequencing the drawdown of provider held unspent funds?	Services Australia will sequence the claim as per the following order: **Non AT-HM services:** • Participant quarterly budget- until exhausted • Commonwealth HCP unspent funds (draw down) • Home care account (HCA) **AT-HM services:** • Commonwealth unspent funds (draw down) • Home Care Account (HCA) • Participant AT-HM funding tier
2	What happens to the home care account (HCA) remaining funds?	HCA will be transferred to the Support at Home program after the final HCP claim. Participants will continue to be able to use their HCA for services until the balance reaches zero.
3	Do providers need to report unspent funds balance monthly as they currently do?	No. Under Support at Home, Services Australia will draw down on the final HCP Commonwealth unspent fund balance which they hold for each of their participants. Therefore, providers will no longer need to report on Commonwealth unspent funds.
4	How will claims drawdown from provider-held care participant contributions (income tested care fee)?	Provider-held participant contributions (income tested care fee) will continue to be managed between provider and participant and will not be tracked by Services Australia.
5	How will providers have visibility of the Commonwealth unspent funds on an ongoing basis?	Participant and provider budgets will be viewable via the Services Australia Aged Care Provider Portal or B2G solution (where applicable). The Services Australia payment statement will provide information reflecting specific claim content –

		it will contain a summary of invoice items claimed and paid, including the relevant contribution and subsidy calculated.
6	How will claiming work in November 2025?	November is a transition period for claims and payments. Providers will use November to finalise all HCP claims and report final balances for any unspent HCP funds they are holding. The HCP Program works on a monthly in arrears claiming cycle so claims for services delivered to 31 October are expected to be settled through the July period. This will also allow for the reconciliation of HCP unspent funds following the closure of HCP program on 31 October. Support at Home claiming will commence from 1 December. The initial claim will be monthly. Providers can continue to claim monthly or move to a more frequent (up to daily) claiming cadence after 1 December. Providers must submit their HCP October claim and Services Australia must approve the claim before Support at Home claiming can commence.

6.3 Support at Home claim evidence FAQs

The below table details questions and responses from the Support at Home claim evidence slide pack.

<table>
<tr><th>No.</th><th>Question</th><th>Response</th></tr>
<tr><td>1</td><td>For which services is evidence required to be uploaded?</td><td>

For AT services, mandatory evidence will be required for all AT high tier claims including the prescription. For claims for participants approved for AT low and medium tiers, evidence will be optional (including prescription claims).
For HM services, mandatory evidence will be required for all HM high tier claims including the prescription. For claims for participants approved for HM low and medium tiers, evidence will be optional (including prescription claims).
The following services will have an optional upload of evidence (for any Support at Home classifications: Support at Home ongoing / Restorative Care Pathway/ End-of-Life Pathway):

<table>
<tr><th>Service Type</th><th>Service</th></tr>
<tr><td>Social support and community engagement</td><td>Expenses to maintain personal affairs</td></tr>
<tr><td>Nursing care</td><td>Nursing care consumables</td></tr>
<tr><td>Nutrition</td><td>Nutrition supports</td></tr>
<tr><td>Transport</td><td>Indirect transport</td></tr>
<tr><td>Home maintenance and repairs</td><td>Expenses for home maintenance and repairs</td></tr>
</table>

Evidence is required to be kept for all claims but is only required to be included in the claim for some services (as above). Refer to question 5 for more information on keeping and retaining records.

</td></tr>
<tr><td>2</td><td>What constitutes evidence?</td><td>The evidence can be an invoice or receipt to substantiate proof of purchase or service delivered.
For AT-HM:</td></tr>
</table>

		• If an item is being claimed, then the invoice or receipt will be submitted as proof of purchase for that item. • If the claim is for a prescription under the services '*Assistive technology prescription and clinical support*' or '*Home modifications prescription and clinical support*', the invoice or receipt will be for the service delivered by the allied health professional. A prescription will also need to be attached separately. • If a wraparound service is being claimed, then the invoice or receipt will be submitted as proof of delivering the wraparound service. • For '*Home modification products*' service, a quote will also need to be attached separately if '*First payment for this item*' is indicated on the claim.
3	What is the purpose and intent of providing evidence?	The collection of evidence will be used for program assurance and data collection purposes. The intent is to substantiate the claimed amount and ensure compliance with program guidelines.
4	What is the evidence preferred format?	Explanations of the structure and file elements for uploading and downloading can be found on the Services Australia website in the Support at Home eKit. Visit Support at Home invoice sample files and refer to the document *Aged Care Support at Home Invoice CSV.* The document that lists out the CSV structure also includes information about what evidence document formats are allowed and includes information about what the filename should be, to enable Services Australia to link back to which invoice item the attachment relates to.
5	What does the department mean by the terminology of 'keeping' or 'retaining' records in	In general, providers should maintain records and evidence to support the claimed amounts and ensure compliance with program guidelines. This refers to record keeping requirements to enable claims for payments of subsidy to be properly verified

<table>
<tr><td></td><td>the Support at Home program manual?</td><td>(paragraph 154(a) of the Act and section 154-3410 of the draft Rules).</td></tr>
<tr><td>6</td><td>When should a prescription be uploaded as evidence and what is the unit of measure that a prescription can be claimed at?</td><td>A prescription can be uploaded whenever a prescription item is claimed under the ‘Assistive technology prescription and clinical support’ or ‘Home modifications prescription and clinical support’ service. This is in addition to the invoice or receipt as proof of service delivered. Mandatory upload of evidence is explained in “For which services is evidence required to be uploaded?”

The unit of measure or unit type for prescription is ‘Hours’ and will correspond to the cost of a prescription service delivered by an allied health professional.</td></tr>
<tr><td>7</td><td>What wraparound services are available for claiming and what is the unit of measure that a wraparound service can be claimed at?</td><td>The wraparound services and unit types available under all Assistive Technology services are:

<table><tr><th>Wraparound Description</th><th>Unit Type</th></tr><tr><td>Set up</td><td>item or hours</td></tr><tr><td>Training</td><td>item or hours</td></tr><tr><td>Delivery</td><td>item or hours</td></tr><tr><td>Administration</td><td>item or hours</td></tr><tr><td>Repairs</td><td>item or hours</td></tr><tr><td>Maintenance</td><td>item or hours</td></tr><tr><td>Other</td><td>item or hours</td></tr></table>
The wraparound services and unit types available under all Home Modifications services are:

<table><tr><th>Wraparound Description</th><th>Unit Type</th></tr><tr><td>Training</td><td>item or hours</td></tr><tr><td>Coordination</td><td>item or hours</td></tr><tr><td>Other</td><td>item or hours</td></tr></table>
Although in most circumstances the department expects the wraparound services to be claimed as ‘hours’, for flexibility the unit type ‘item’ is also available where it may apply.

Where a wraparound service does not closely relate to a specific wraparound category from the list, the ‘Other’ category should be used, and a text description must be provided in the claim to describe the wraparound service.</td></tr>
</table>

7. Appendix B - Support at Home pre-transition contribution rate examples

7.1 Participants approved for a Home Care Package on or before 12 September 2024

Care recipient category	Example
Category A – Home Care Package non-fee payer	Sandra gets a full age pension. She applied for a Home Care Package in July 2024 and completed a means assessment, which found that she: • was not liable to pay an income tested care fee • was liable to pay a basic daily fFee. From 1 November 2025, Sandra will no longer be liable to pay a basic daily fee. This means Sandra won't pay anything for her care — her contribution percentage under Support at Home will be 0%. This is because she was approved for a Home Care Package on or before 12 September 2024 and did not have to pay an income tested care fee.
Category B – Home Care Package fee payer	Bob applied for a Home Care Package in July 2024. Based on his income, he was liable to pay an income tested care fee of $37.70 per day towards his care. He has heard about the Support at Home program and wants to understand if this will change the amount he contributes towards his care. Because Bob was approved on or before 12 September 2024, he's protected by the 'no worse off' principal. This means that from 1 November 2025, Bob's contribution will be reviewed under the special contribution rates for Support at Home, which might change

	the amount he has to pay. However, because he was approved for a Home Care Package on or before 12 September 2024, he won't have to pay more for care under Support at Home.
Category C – Home Care Package approved on or before 12 September 2024, but there is no entry recorded in the Aged Care Provider Portal and/or fees have not been set	Harvey was approved for a Home Care Package before 12 September 2024, but he hasn't finished his income assessment yet. He's also waiting for a place to become available. Harvey has heard about the new Support at Home program starting on 1 November 2025 and wants to understand if this changes the amount he will have to contribute towards care he receives in the future. Harvey was approved on or before 12 September 2024 and is protected by the 'no worse off' principal. This means his contribution towards care will still be calculated based on income only using the Home Care Package rates, even after he moves to the Support at Home program on 1 November 2025. Because Harvey is not currently receiving care and does not have a current means assessment with fees set, Services Australia can't estimate what his contribution may look like. However, Harvey can use the fee estimator on the My Aged Care website to get a general idea of the percentage he may have to contribute towards the cost of his care under Support at Home.

7.2 Participants approved for a Home Care Package after 12 September 2024

Care recipient category	Example
Category D – Care recipient is receiving an income support payment	Monica was approved for a Home Care Package after 12 September 2024. She receives the age pension and has already given her income and asset details to Services Australia. She's currently receiving in-home care and has heard she'll move to the new Support at Home program on 1 November 2025. Monica wants to understand how this change might affect what she contributes towards her care. Because Monica was approved after 12 September 2024, her contribution towards her cost of care will be calculated under the Support at Home rules. Services Australia will use the income and asset information she's already provided for her age pension to estimate her contribution rates. This estimate will be shared with her provider from 1 October 2025, and they'll talk to her about what her contribution towards her cost of care might be from 1 November 2025. From 1 November 2025, Monica's contribution rate will be set using income and asset details Services Australia has on file from that date.
Category E – Care recipient is a self-funded retiree receiving in-home care	Lauren was approved for a Home Care Package after 12 September 2024 and is receiving in-home care. She is a self-funded retiree, which means she doesn't

	receive an income support payment like the age pension. Lauren has heard about the new Support at Home program and wants to know what her cost of care will look like when she transitions to Support at Home from 1 November 2025. Because Lauren was approved for a Home Care Package after 12 September 2024, her cost of care will be calculated under the Support at Home rules. Services Australia can use the income details Lauren provided when she completed her home care means assessment to estimate her contribution rates for Support at Home. This estimate will be shared with her provider from 1 October 2025, and they'll talk to her about what her contributions for her care might be from 1 November 2025. From 1 November, Lauren's individual contribution rates will be temporarily set using her income details only. Services Australia will send Lauren a request for income and asset details which will be used to calculate her contribution rates under Support at Home. If Lauren does not respond to Services Australia's request to provide income and asset details, she may be asked to pay maximum contribution rates towards her care. The outcome of Lauren's new means assessment may change the amount

	she is required to contribute towards her care.
Category F – Care recipient does not have a provider, but wants to prepare for the future	Paul was approved for a Home Care Package after 12 September 2024 but isn't currently getting help at home. He's been finding things harder lately and thinks he'll need support soon. He wants to know how much he might have to contribute towards the care he receives at home in the future. Paul can use the fee estimator on the My Aged Care website to get a general idea of the percentage he may have to contribute towards the cost of his care under Support at Home.

8. Further information and resources

To stay up to date, please refer to the Support at Home program webpage and subscribe to the department's Your Aged Care Update newsletter.